#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death #1. Per Phys. PGC 1-27-06 cr 3. Time of Death 2. Date of Deeth 1. Decedent's Name (First, Middle, Last) Arlene, M. Leister JAN. Physician 24,2006 /Medical 4b. City, Town, or Location of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street and number) Examiner FREDERICK FREDERICK BEVERLY HEALTH CARE CENTER If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Yeer) 7. Age (In yrs. lest birthday) 5. Social Security Number Months | Days **Funeral** 1 □ M 2 🙀 F Yrs. JUNE 27, 1923 PA. 215-52-6814 Director Usuel Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. Stete r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 □ No Directo COLUMBIA HOWARD MD. 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number U.S.A. 6336 CEDAR LA. 21044 e filed within 72 hours after death is likygiene. other than "natural", or ftems 23 Funeral Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify. Baltimore, Maryland 21215-0020 ģ WHITE 31 Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) MONTGOMERY CO. PUBLIC SCHOOL Elementary/Secondary (0-12) College (1-4or 5+) PRE-SCHOOL AIDE 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Health and Mentel Hy Important: If Item 27 Ia marked oth any injury or other traumatic even VIOLA KLINGER GUINTHER RALPH 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 490 WINDING BROOK RD., BIGLERVILLE, PA. 17307 ROBERT J. PROCTOR/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State SILVER SPRING, MD. GATE OF HEAVEN CEMETERY 1-27-2006 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility CHAMBERS FUNERAL HOME & CREMATORIUM, P.A. 5801 CLEVELAND AVE., RIVERDALE, MD. 20737 M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician COLON CANCER. Immediate Cause (Final disease or condition resulting in death) /Medical Examiner MILUNE Physician/Medical Examiner siclan end burial-transit Attending Physician: The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or as e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No ģ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No 1 Tyes 26. Plece of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manger of Death 28b. Time of 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be determined

Division of Vital Records, P.O. Box 68760, r death. Director efter 6 To the Hospital within 24 hours e To the Funeral Completely filled

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

edical

4 Homicide

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOUSE AVE. FREDERICK. MD 21701 2. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

29c. License number

00047951

29d. Date signed (Month, Day, Year)

For	Stat	te of Maryland	/ Department of Health and M	1ental Hygi	ene	01000
State Registrar			Certificate of Death	Reg	2.006	04002
cedent's Name (First,	, Middle, Last)			2. Date of Death Month	Dav Year	3. Time of Death
DOCTOR	CLYDE	LEWIS	•	JANUARY	/	8:14 P M

Months

	1. Decedant 3 reams (/ // or	, ,,,,,,,,,,	
Physician /Medical	DOCTOR	CLYDE	LEV
Examiner	4a. Facility Name (If not in	stitution, give street a	nd number)
	CDEATED BAT	TTMODE ME	DICAL

76

JANUARY 22,2006

GREATER BALTIMORE MEDICAL CENTER 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex

**X**XM 2□ F

TOWSON

4b. City, Town, or Location of Death

4c. County of Death BALTIMORE

**Funeral** Director

"naturei", or iteme 23a or 28e-f show

d 2 should be fited within 7 th and Mental Hygiene.

ewis, 1

Baltimore, Maryland 21215-0036

227-32-8115 Usual Residence of Decedent 10a. State 10b. County

10c. City, Town or Location

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Nov. 20, 1929

 Birthplace (State or Foreign Country) Halifax, Va.

Md. Directo

Towson

Baltimore

10d. Inside City Limits 1 No 2 No

10e. Street and Number

1123 Ramble Rd #B

10f. Zip Code 21239 10g. Citizen of What Country? U.S.A.

1 Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 No Specify:

14. Race - American Indian, Black, White, etc. Specify:Black

15. Decedent's Education

(Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Labor Warehouse

Unknown

18. Mother's Name (First, Middle, Maiden Sumame)

John I.Lewis

Elementary/Secondary (0-12)

19a. Informant's Name/Relationship (Type, Print)

Kate Stephens

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1123 Ramble Rd. #B Baltimore, Md. 21239

Tyrone C.Lewis-Son

21. Signature of Funeral Service Licensee

20a. Method of Disposition t ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date 20c. Location - City or Town, State

Lewis Family Cem. 1-28-2006 Halifax, Va.

**Physician** /Medical Examiner

burial-transit

nding physician and use as the burial-tran

Division of Vital Records, P.O. Box 68760

of or Attending Patter death.

To the Hospitei within 24 hours a To the Funsrei C

Director

Examiner

Physician/Medical

2

permit. Pages 1 and 2 s
Department of Health at
importent: If Item 27 is
any injury or other treu

23a. Pahl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Dunn & Sons 5635 Eads St, N.E.

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Failur rende Acute Due to (or as a consequence of) vascular Paripheral

Due to (or as a consequence of). hypertension
Due to (or as a consequence of):

heart

5 Pending

investigation

6 Could not be determined

IF FEMALE 23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

Year

Approximate Interval Between Onset and Death

unknowin

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tailure

9 Unknown

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

COMMESTIVE hyperlipidemia

24a. Was an autopsy 1 Yes 2 No

26. Place of Death (Check only one)

Timonium

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner? 1 Yes 2 No

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

4 | Homicide 29a. Certifier (Check only

27. Manger of Death

1 Natural

2 Accident

3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Katherine a aspeli A.O.

H0054970

29d. Date signed (Month, Day, Year)

MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Timonium 31. Date filed (Month, Day, Year)

JAN 2 7 2006

Rd. 32. Registrar's Signature

State Registrar

David Le 06-00623 CT		Amend Unpend item#	1,23a,27,per State of	r <b>int in E</b> VE. g853 Marylan	<b>3/8/06</b> 3/8/06 d / Depa	<b>delible</b> IT artmen	e Ink. It of H	<b>Ens</b> uealth a	ire Al and M	lental Hy	s Are /giene	Legible.	
		1 - Stata Registrar		_	Cei	tificat	e of L	Death			Reg. No.	) [ ] [ ] [	04003
Physic	ian	Decedent's Name (First, Middle,	Last)							2. Date of D Month	Day		
/Med	ical	David Junior Lew 4a. Facility Name (If not institution,		er)		4b City	Town or	Location of	of Death	Janua:	-	200 County of De	
Exami	ner	505 Gay Street		01)			brid		JI 5 001.11			orches	
Funera		5. Social Security Number	5. Sex 7.	Age (In yrs.	last birthday)		r 1 Year	If Under Hours	24 Hrs. Min.	8. Date of B	irth	9. B	rthplace (State or Foreign
Director		223-17-3570	1 <b>25</b> M 2□F	40	Yrs.	WOTERS	Days	riodis		June 3	,1965	Ma	ryland
and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
Maryi -f •hc	ţō	Maryland Dorches	ster	Cam	bridge								1 <b>∑</b> Yes 2 ☐ No
h the	Director	10e. Street and Number	7002	1		10f. Zip	p Code				10g. Citi	izen of What (	Country?
ind 21215-0036 be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or Iteme 23e or 28e-f ehow event, if a Mydical Examinar must be notified at	raiD	505 Gay Street					513_				USA		
er des	Funeral	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Nas Dece f Yes, spe	dent of H ecify Cuba	ispanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-	14. Race - An Black, Wh	
nrs aft	by F	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date	_		1 🗆 Yes	2 🔀 No	Specify:				Specify: Wh	ite
2 hou	ted	15. Decedent' (Specify only highest	s Education		16a. Dece	ient's Usu	al Occup	ation during mos	t of work	ina	16b. K	ind of Busines	s/industry
21.0 F in	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT u	ise retired	)		,	Fac	+ Food	Resturant
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d be figured by the stand of c eve	To Be	David Junior Le						Lore	tta :	Young I	oske	У	
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-1 show any injury or other traumatic event, Ital Madical Examination must be notified at	F	19a. Informant's Name/Relationsh			19b. Mailir	ng Addres	s (Street	and Numb	er or Run	al Route Num	ber, City o	or Town, State	, Zip Code)
and 2 selth a		Carol Somers/Ha	lf Sister		_			St.	-			and 21	
altimore, mit. Pages 1 ar pertment of Hee portant: If Item 5 ploury or other case.		20a. Method of Disposition 1 Durial 2 Coremation	3 □Removal from St.	ate	Place of Dispo cemetery, crei	natory or	other plac			Date		ocation - City o	
tim trment tant:		4 Donation 5 Other (Sp		Sa	lisbur				2/8/0			Soury, P	Maryland
Balt Permit. Depertimport Import	4	21 Signature of Funeral Service L		CD	H	ollo	way I	uner	ăl H	ome P.	A.	Marvla	nd 21804
		23a. Part 1. Enter the disease, or	mplications that cau	of used the deat		-							Approximate Interval Between
Physician		shock, or heart failure. List of Immediate Cause (Final			rterioso	:lerot:	ic cai	rdiovas	scular	r diseas	е		Onset and Death
/Medica		disease or condition resulting in death)	a	as a consec									
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ed sit	xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consec	quence or):								
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68 tifficat og phy as th	Medi	IS SENING											1
sion of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be executed asth.  or: After this certificate has been signed by the attending physicien and the funeral director, page 2 should be detached for use as the burial-transit.	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		h 2 Feta	al death 3	Ectopic p		,				23d. Date of o	lelivery Day Year
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Division of Vital Records, or attending Physician: The law requires taller death.  Director: After this certificate has been signe in by the tuneral director, page 2 should be e	ifica	3 Suicide 6 Could n	ot be 28e. Place o	f Injury - At h	ome, farm, st	reet, facto	ory, office				(Street ar		Rural Route Number,
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Division To the Hospital or Attending 24 hours after death To the Funeral Director: completely filled in by the		29à Certifier 1 ☐ Certifyin (Check only 2 ☑ Medical I	g Physician: To the b Examiner: On the bas	is of examina	owledge deal ation and/or in	h uccuma vestigatio	d at the ti	ne, date a pinion, de	nd place ath occur	and due to the	e, date an	) and manner d place, and d	ue to the cause(s)
the Phin 24 thin 24 the F	Medical	29b Signature and title of certifier	and manne					e number			,		onth, Day, Year)
To To com	1	The state of the s	lo MI			2.		CME				ary 26	
•		30. Name and address of person	who completed cause	of Jeath (Ita	m 23a) (Tvoe	Print)	U	OLIL			Jane	ary 20	, 2000
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	Physici		1. Decedent's Name (First, Middle, I Catherine Marie							I	2. Date of Dea Month ebruar		å, 2006	3. Time of Death 7:22 P M
	/Medic Examin		4a. Facility Name (If not institution, g				4b. City,	Town, or	r Location	of Death		-	c. County of Dea	th
3	Funeral		100 East Carrol 5. Social Security Number 6		je (In yrs. i	last birthdey	If Under				8. Date of Birt	h	Wicom- 9. Bir	LCO thplace (State or Foreign ountry)
1	Director		214-82-5256	1□M 2⊠F	44	Yrs.	Months	Days	Hours	Min.	(Month, Day March 2	y, Yea 28, 1	1961 Nor	th Carolina
	yiand now		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or L	ocation							10d. Inside City Limits
	Ba-f el	Director	Maryland Wicomic	:0	Sali	sbury	1							1 Tes 2 No
	3a or 2		10e. Street and Number  1314 Woodland Ro	- A			10f. Zip						citizen of What Co	ountry?
	r deeth	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	S. 13.	Was Deced	tent of H	lispanic C	rigin? (Spe	cify Yes or No- Rican, etc.)	USA	14. Race - Ame Black, Whit	
336	urs afte	by	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:	No		1 🗆 Yes	2 <b>M</b> No	Specify	y:			Specify:	nite
2-0	within 72 hours after deeth with the Maryland ene. then "netural", or items 23e or 28e-f ehow he Medical Exercities must be notified at	eted	15. Decedent's (Specify only highest of	Education arade completed)		(Give	dent's Usua kind of wo	rk done d	durina ma	st of working	ig	16b.	Kind of Business	
Baltimore, Maryland 21215-0036	is 1 end 2 should be filed within 72 hours after deeth with the Marylan of Heelth and Mental Hygiene. Item 27 is marked other then "natural", or items 23e or 28e-f ehow other treumetic event, the Medical Exaction must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or s	5+)	Nurse	DO NOT us	se retired	1)			Н	ealth Ca	ro
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ıyla	should od Men marke imetic	<sup>2</sup>	Robert E. Meehan  19a. Informant's Name/Relationship	(Type, Print)		19b. Maili	ina Address				. Barlo		or Town, State,	Zin Code)
Σ 8	end 2 selth ar n 27 is er treu		Bryan LeCompte/H				_					_	land 21	
ore	or oth		20a. Method of Disposition 1   → Burial 2   → Cremation 3			lace of Displemetery, cre				-	ate		Location - City or	
ıţ	permit. Peges Department of I Importent: If it eny injury or of		4 □Donation 5 □ Other (Special Signature of Funeral Service Lice		Par	rsons	2. Name an	d Addres	ss of Faci	2/10/0			lisbury,	Maryland
ä	Depar Impor		Kill R	beiney (	FSP		01 Sn	ow H	ill	Rd. S		у,_	Marylan	d 21804
			23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	ly one cause on each li	ne.		ter the mod	e of dyin	g, such a	s cardiac or	respiratory an	rest,		Approximate Interval Between Onset and Death
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60,	9 5 5	ш	resulting in death) Last	Due to (or as	a consequ	uence of):								
687	ficate if	edica		d										
30X	eath certificate be exatending physicien for use as the buria	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1□Live birth	of pregnat		⊒Ectopic pr	egnancy					23d. Date of de	
0.	thet the desired by the all	Physiclan/Medical	1 Yes 2 No	4□Pregnant at 9□Unknown	time of de	eath 5	Other (sp	ecify)					Month	Day Year
o. O.	es thet gned b		Part II. Other significant conditions	contributing to death b	ut not resu	ulting in the u	ınderlying c	ause grve	en in Part	1.	23e. Did to	bacco	use contribute to	the cause of death?
ord	w requires the been signed I should be det	eted	Cocaine Use					·						robably 4 DUnknown
Division of Vital Records, P.O. Box 68760	The law te has aga 2 a	Completed by	-								24a. Was a autop: perfor	sy med?	death?	utopsy findings available completion of cause of
Vital	icien: sartifice ector, p	Be	25. Was case referred to medical exeminer?	Hannita II				104		e of Death	(Check only or	2 □ N ne)	0   Z 165	
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sion	ottending death. ctor: Aft y the fun	catio	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	on 2/4/06		7:10	Рм	1 🗆 '	Yes 2		unk			
Divis	s aftar d ai Direct ad in by	Certification:	3 Suicide 6 ACould not determine			me, farm, st	reet, factory	, office		2	8f. Location (S City or Tow Salisbury	treet a m, Sta	ind Number or Rive) 100 fast	Carroll St.
	To the Hospital or Attending Physicien: The law requires that the death certificate be within 24 hours affar death.  To the Funeral Director: Affer this carrificete has been signed by the attending physicis completely filled in by the funeral director, paga 2 should be detached for use as the but	Medical	29a. Certifier 1 Certifying F	Physician: To the best aminer: On the basis of and manner sta	examinati	wledge, deat ion and/or in	h occurred avestigation,	at the tim in my of	ne, date a pinion, de	ind place, a ath occurre	nd due to the c d at the time, d	ause(:	s) and manner as nd place, and due	s stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	100		1	29c		number				ate signed (Mont	-
			30 Name and address of	talla	UV	nd	Prig **		O.C.M	1.E.	L	ebi	ruary 05	, 2006
			30. Name and address of person wh	ALLA	Ung	d111	-	Stre	et,	Balti	more, N	lary	yland 21	201
ą	Stat Registra	_	31. Date filed (Month, Day, Year) FEB 0 8	2006 32. Registra	_	ture & A	Company of	è						
				FORE ENGLIS	William P.	W	ALCOHOLD STREET							

				State of	f Marylar	•	rtment of I tificate of		and M		giene Reg. No. 0	6	04005	
			1. Decedent's Name (First, Middle, La	st)						2. Date of Dea	ath		3. Time of Death	-
	Physici /Medi		Harold Warren	Larsen						Month Januar	y 26, 20	Year 006	7:30 a.m.	
-	Examir		4a Facility Neme (If not institution, giv	e street and nun	nber)			4b. City, To	wn, or Lo	cation of Death	4c. County	of Death		
1			Brooke Grove Nu	rsing Ho	ome			Sandy	Spi			gome	ry	
	Funeral Director		5. Social Security Number 6. S 027-14-7095	Sex M 2 F	7. Age <i>(In yrs.</i> 8	last birthday) 2 Yrs.	If Under 1 Year Months Days		24 Hrs. Min.	8. Date of Birt (Month, Da April	h , Year) 5, 1923	Cour	place (State or Foreign place) sachusetts	
	put		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	eation					1	0d. Inside City Limits	_
	laryla sho	5			100.01							'	1 ☐ Yes 2 ☐ No	
	the N	Director	Maryland Montgon  10e. Street and Number	nery		01ne	10f. Zip Code				10- 04: 11	III at Caus		_
	with po o	ā	3621 Queen Mary	Drive			20832				10g. Citizen of V	USA	illy ?	
	eath	era	11. Marital Status	12. Was Dece	dent Ever in U	IS 13 V	Vas Decedent of I	Hispanic Orio	nin? (Sne	cify Yes or No-	14 Bace		an Indian,	_
21215-0020	be filed within 72 hours after death with the Maryland ital Hygiene. I hatural, or items 23a or 28a-f show other than "natural," or items 23a or 28a-f show event, the Medical Examiner mast be notified at	by Funeral	1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed For	ces? 2 ∐ No	If	Yes, specify Cub  ☐ Yes 25 No	an, Mexican	, Puerto	Rican, etc.)	Blac	k, White, Whit	etc.	
Ō	2 ho	Completed	15. Decedent's Ed	fucation		16a. Deced	ent's Usual Occu	oation			16b. Kind of Bu	siness/Ind	dustry	_
215	within 7 iene. than "r	e d	(Specify only highest gra	College (1	4or 5+)	life. D	kind of work done O NOT use retire	d) d)	or worki	ng				
	ad with rgiene. er thar	5		5+		Aı	nalyst				Federa	al Go	vernment	
nd	be filed ntal Hygi od other event, I	Be (	17. Father's Name (First, Middle, Last,					18. Mothe	r's Name	(First, Middle,	Maiden Surnam	e)		
yla	should be filed vind Mental Hygie Ind Mental Hygie I marked other I umatic event, III	2	Ole Christian La	arsen				Ann	ia Ca	arlson				
Maryland	2 sho and iam aum		19a. Informant's Name/Relationship (				g Address (Street							
6)	and lealth m 27 her to		Kathryn R. Larsen	n/ Wile	201 5		Queen M	ary Dr	ive,					_
0	ges 1 t of H if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from S	State	cernetery, crem	ition (Name of atory or other pla		Ja	Date an. 27,	20c. Location -	City or To	wn, State	
Ë	tmen tant: jury	9	4 □ Donation 5 □ Other (Specify	·	Met		n Cremator			2006			Virginia	_
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta important: If item 27 is merked eny Injury or other traumatic ev DDC8.		21. Signature of Funeral Service Licer	1 Colo	2		Name of Many						, MD 20901	
			23a. Part1. Enter the disease, or corn shock, or heart failure. List only	plications that ca	used the deat	h. Do not ente	r the mode of dyi	ng, such as	cardiac c	r respiratory ar	rest,		Approximate Interval Between	
)	Physician /Medical Examiner		Immediate Cause (Final disease or condition	<u> </u>			ATURY					-	Onset and Death	
	Ladillillei	_	resulting in death)	u		or as a consequ						İ		
	ed sit	edical Examiner		6 CARC	NIC	OBST	RUCTIV	EL	UN	6 DE	EASE	1	MEARS	
	icate be executed physician and s the burial-transit	xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		Due to (c	or as a consequ	ence of):							
68760,	slciar burit	ai	cause. Enter Underlying Cause (Disease or injury that initiated events	c								i		_
687	ficate physics the		resulting in death) Last		Due to (o	r as a consequ	ence of):							
Вох	centi nding use a	2		d									-	
ă	death a atte d for	icla	Part II. Other significant conditions of	antributing to do	th hut not roo	ultina in the co	de de de cione e in	on in David		Oah Didt		deile de de	the cause of death?	-
P.O.	The law requires that the death certif ite has been signed by the attending page 2 should be detached for use a	/ Physiclan/M	Fartii. Other significant conditions of	ontributing to dea	ith but not res	uiting in the un	derlying cause giv	en in Par( i.				3 Prob	•	
Division of Vital Records,	uires 1 sign 11d be	d by								24a. Was a	in autopsy	24b. We	re autopsy findings	Ì
<del>ဂ</del>	v req beer shou	lete								perfor	med?	cor	ilable prior to npletion of cause death?	J
æ	e has	Completed								4 🗆 V	abilita			
<u>ra</u>	in: Ti ificat or, pa	ပ္ခဲြ	25. Was case referred to medical				V	GE Plans	of Dooth	1 ☐ Y			Yes 2□ No	-
>	slois cert direct	To Be	examiner? 1 ☐ Yes 2 🗽 No	Hospital:	patient 2 🗆	ER/Outpatient	3□ DOA Oth				ence 6 □Othe	v /Coonié	4)	
ō	ding Physician: The land that the land that this certificate hat funeral director, page		27. Manner of Death	28a. Date of	Injury	28b. Time of	28c. Injur Wor				ow injury occurre		/	
0	ath. r: Afte e fun	윭	1 Natural 5 ☐ Pending 2 ☐ Accident investigation		, Day Year)	Injury		γγ Yes 2 □ N	lo					
<u>N</u>	al or Attending Physicien: T s after death. Il Director: After this certificat ed in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place	of Injury - At ho g, etc. (Specify		et, factory, office		2	8f. Location (S City or Tow	treet and Numbe	r or Rura	Route Number,	
ō	halor na Dia ed in	ည်		Danging	g, etc. (opean)	"				ony or rom	, Claidy			
	To the Hospital or y within 24 hours after To the Funeral Direct completely filled in the tendent of the tenden	edical	29a Certifier (Check only one) 2 Medical Exam	rsician: To the bas iner: On the bas and manne	is of examinat	wledge death tion and/or inve	scourse at the tirestigation, in my o	ne date and pinion, death	place a occurre	nd due to the e	auce(c) and mar ate and place, a	ner se et nd due to	ated the cause(s)	
	To ti To ti		29b. Signature and title of certifier				29c. Licens	e number		2	9d. Date signed	(Month, L	Day, Year)	
			10minut	M	7		023	174		7	ANDAR	y Da	5,2006	
1	2+1		30. Name and address of person who d	completed cause	of death (Item	23a) (Type, P	rint)	118						1
	ω··	1	FUNIS M. HAN	1 MON	no 29	901 OL	NEW SA	NOY	30	RING	COND/	OLN	En	
	Stat Registra	e	31. Date filed (Month, Pay Year)	2006 32. PM	gistrar's Signa	ture	NEY SA					M	als in the	,
	- negisti t	4	•	1	and the second									- 1

		1 – For State Registrar	State of Maryland		artmen rtificat					Reg. No	nna	04006
Physici /Medic Examin	al	Decedent's Name (First, Middle, Last)     Charlene Mod     4a. Facility Name (If not institution, give s	ore		4b. Cily,	Town, or	Location of [	J	Date of De Month	ry :	22,200 C. County of Dea	
Funeral Director		5//-94-112/	and Hospita 7. Age (In yrs. I	ast birthday)	C If Under Months	lint 1 Year Days	If Under 24	Min.	Date of Bir (Month, Da	rth a <i>y, Year,</i>	9. Bir	Georges thplace (State or Foreigountry) sh., DC
a-f ehow	ctor	Usual Residence of Decedent           10a. State         10b. County           MD         PG		Itla:								10d. Inside City Limits  Y Yes 2 □ No
72 hours after death with the Maryland natural', or Iteme 23a or 28a-1 ehow Sical Examiner must be notified at	by Funeral Director	10e. Street and Number  3302 Curtis Dr.  11. Marital Status  1  Never Married 2 Married 3 Widowed 4 Divorced	ive #T3  12. Was Decedent Ever in U. Armed Forces?  1			0746 dent of H city Cuba	ispanic Origir n, Mexican, f	n? (Specif Puerto Ric	fy Yes or No can, etc.)	Un	itizen of What C  ited S:  14. Race - Am Black, Whi  Specify: B1	tates erican Indian,
d within giene. or then "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12) 1 2 17. Father's Name (First, Middle, Last)		16a. Dece (Give life. Bank	kind of wo DO NOT u	rk done d se retired	durina most o			Pr	ivate	
2 should be and Mental le marked o aumatic eve	To Be	Charles G. Sibe	pe, Print)		-		Rosa and Number	L. or Rural F	Cole	S oer, City	or Town, State,	Zip Code)
ges 1 and t of Healt if item 2 or other		Alvin Moore/hu  20a. Method of Disposition  1 Agurial 2 Cremation 3 A  4 Donation 5 Other (Specify)	lemoval from State	emetery, crei	natory or c	itner piac	Driv aryla em. 1				ocation - City o	
permit. Pa Departmen Important: eny injury		21. Signature of Funeral Service License  21. Signature of Funeral Service License  23. Page 22. Enter the disease, or compli	devard	2/3	910 :	Silv	er Hi	ill	ges 8	& Ec	dwards	
death certificate be executed  Example and privilegan and tor use as the burial-transit	icai Examiner	if any, leading to immediate	Due to (or as a consequence to (or a))).	Jence of): JEST Jence of): FA			BLE	E-D				Interval Between Onset and Death
that the death certificated by the attending pridetached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de	death 3	∃Ectopic pi ∃ Other (sp					The state of	23d. Date of de Month	elivery Day Y <i>e</i> ar
law requires inat as been signed b 2 should be deta	þ	Part II. Other significant conditions cor	ntributing to death but not resu	ulting in the u	nderlying o	ause giv	en in Part I.				_	to the cause of death?
ate h page	Completed								24a. Was auto perf 1 Yes		prior to death?	
Attending Physician: The death.  ector: After this certificate by the funeral director, page	atlon: To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	lospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o Injury		28c. Injun Wor	er: 4 □ Nurs	ing Home		idence	6 ☐ Other (Speury occurred	ecity)
To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify		reet, factor	y, office		28	f. Location City or To	(Street a own, Stat	und Number or F te)	Rural Route Number,
To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by	edical		sician: To the best of my kno ner: On the basis of examina and manner stated.									
To the within 2 To the complet	M	29b. Signature and title of certifier  30. Name and address of person who co	Displayed cause of death (Item	23a) (Tune			-8128	3		29d. D.	ate signed (Mon	200 6
Sta Registr			2 OXON HILL 32. Registrar's Signa	Reto	अह	500	OXON	HL	LA	10	20741	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician James Joseph McQuiggan, Jr. 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Kegional medical Center If Under 1 Year If Under 24 Hrs. Keninsula NICOMICO 5. Social Security Number Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1**X** M 2□ F Months Hours Vre 8/10/1931 **Director** 180-24-0955 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits or Iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes 2 No Director MD Worcester Berlin 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 858 Ocean Parkway 28111 USA Funeral Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 20 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White þ 3 Widowed 4 Divorced 'naturel', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Foreman Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be i Department of Health and Mental I Important: If Item 27 ie marked o James Joseph McQuiggan, Sr. Juanita Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lenore McQuiggan 858 Ocean Parkway, Berlin, MD 21811 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Sunset Memorail Pk. 2/2/2006 Berlin, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part1. Enter II- Vsease, ir complications in shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician 10 genic /Medical Due to (or as a consequence of): Examiner Coron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 20 No 1 Yes of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No 2 1 Yes Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No I hours after death funeral Director; 2 Accident the th 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 THomicide To the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 55658 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arena. m.s. 30415b4M FrANK 100 E. CAPAIL SY. 31. Date filed (Month, Day, Year) State FEB 0 1

DHMH 17 Rev 1/2001

Registrar

			1 - For State Registrar	State of Mar	-	partment o				giene	006	04008
100	S. J. Jan.	37	1. Decedent's Name (First, Middle, Las	(t)				2	2. Date of Dea		Year	3. Time of Death
	Physici /Medic		Richard Earl Mer						JAN.	27	2006	1605 M
	Examin	ner	4a. Facility Name (If not institution, give		Carlos	4b. City, To	wn, or Location of	of Death		4c. C	ounty of Death,	
	Funaval		5. Social Security Number . 6. S.		(In yrs. last birthda	y) If Under 1		24 Hrs. 8	8. Date of Birt	h	9 Birthr	place (State or Foreign ntry)
	Funeral Director		483-28-2727	MM 2□F 79	Yrs.	Months E	ays Hours	Mh. Se	(Month, Da) eptembe	er <sup>2</sup> ,	1926 <sup>Cou</sup>	ntry) Iowa
2	D .		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location						10d. Inside City Limits
	ehov	ī			•							1 1 Yes 2 □ No
	28e-f	Director	Maryland Wicomic  10e. Street and Number	0	Salisbur	10f. Zip Co	ode			10a. Citize	n of What Cou	ntry?
	death with the Maryland ms 23a or 28e-t ehow [must be notified at	0	231 Canal Park D	rive		2180				USA		,
	death	Funeral	11. Marital Status	12. Was Decedent Ev		3. Was Deceden		igin? (Spec	ify Yes or No	- 14	Race - Ameri Black, White,	
2	or ite	by Fu	1 Never Married 2 Married	1 <b>X</b> ]Yes 2 ☐ No. If Yes, Give	JS ARMY	1 Yes 20					necify:	
5-003b	y within 72 hours after death with the Marylan jiene. r than "naturel", or items 23e or 28e-1 ehow the Madical Examiner must be notified at		3 ☐ Widowed 4 ☐ Divorced  15. Decedent's Ed			cedent's Usual C	ocupation.		1		of Business/In	WHITE
Š	n "na	plet	(Specify only highest gra	de completed)	(Gi	ive kind of work of DO NOT use	done during mos retired)	t of working	g	TOD. TRITIC	01 003111033411	idusity
7	d with	Completed	12	College (1-4or 5+)		Presid	ent			MarDe	elVa Nev	ws Company
yland	uld be filed dental Hygid rked other tic event, III	Be (	17. Father's Name (First, Middle, Last)						(First, Middle,		umame)	
<u>8</u>	D 9 2 0	1º	Samuel Edward Mer  19a. Informant's Name/Refationship (1)		105 14	line Address (C			en Ram		Chan 7:	- 0- (-)
<u>8</u>	s 1 end 2 shou f Health and M item 27 is mar other treumati		Marilyn J. Mercer			alling Address (S Canal I						
ē,	s 1 en if Hea item other		20a. Method of Disposition		20b. Place of Dis	sposition (Name trematory or othe	of or place)	Da	ite	20c. Loca	ation - City or To	own, State
Ē	Pages nent of int: If it		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Salisbur			1/30/0	06	Salis	bury,Ma	ryland
Baitimore,	permit. Pages Department of I important: If it eny injury or o	-	21. Signature of Funeral Service Licen	see	CESP	Hollowa	Address of Facility Funera	ăl Ho	me P.A			
11	g 0 5 5 9		Carrie H. Co	magno		501 Sno	w Hill I	Rd. S	alisbu:	ry, M	aryland	
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	one cause on each line.	ie death. Do not i	enter the mode o	r dying, such as	cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
Ĭ.e	Physician /Medical		fmmediate Cause (Final disease or condition resulting in death)	a	B CELL	Lymp	LOMA					ZYRS
	Examiner			Due to (or as a	consequence of):							
	7 =	ner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a )	consequence of):							
	and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
8/60,	ate be executed thysicien and the burial-transit		Tooking in doubly Eddi	Due to (or as a o	consequence of):							
289	certificate be executed Iding physicien and Ise as the burial-transit	edical		d								
XOD	n certii anding use a	n/M	fF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		ome with the				23	d. Date of deliv	ery
ņ	death se atten	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown		3 ∐Ectopic pregi 5 ☐ Other <i>(speci</i>					Month	Day Year
т Э	that the ed by th detache	Phys	9 Unknown						T 00: B/4:			
S,	w requires that the death certifica been signed by the attending pl should be detached for use as t	þ	Part II. Other significant conditions of	ontributing to death but	not resulting in the	underlying caus	e given in Paπ I.	•	239. Did to			he cause of death? babfy 4 □Unknown
ecords,	v requires been sign should be	etec							24a. Was			opsy findings available
ě	e la has	Completed							autop perfo	rmed?	prior to co death?	impletion of cause of
VII	u <b>cian:</b> Th certificate rector, pag	0	25. Was case referred to medical				26 Place	of Death /	1 ☐ Yes (Check only o	me)	1 🗌 Yes	2□ No
	G X	ToB	examiner?	Hospital:	2 ER/Outpat	ient 3 DOA	Other				Other (Specil	(y)
	Jing Ph After th funeral		27. Manner of Death  Salatural 5 ☐ Pending	28a. Date of Injury (Month, Day )	/ear) 28b. Time Injur		Injury at Work?		3d. Describe h	now infury	occurred	
DIVISION	Attending r death.	Icat	2 Accident investigation 3 Suicide 6 Could not be		. At home farm	M Street (autor)	1   Yes 2   1		of Location /	Stroot and	Number of Pur	al Route Number,
2	after of Direction by	ertification;	4 Homicide determined	28e. Place of friung building, etc.	(Specify)	street, ractory, o	IIICe	20	City or Tox		Various of har	ai noute ivaniber,
	o Hospital or Attend 24 hours after death 25 Funeral Director: ( 91ely filled in by the f	O	29a. Certifier Certifying Ph	ysician: To the best of	my knowledge, de	eath occurred at	he time, date an	nd place, an	nd due to the	cause(s) a	nd manner as s	stated.
	To the Hos within 24 h To the Fur	ledical	one) 2 Medical Exam	niner: On the basis of e and manner state	xamination and/or	investigation, in	my opinion, dea	ith occurred	d at the time,	date and p	lace, and due to	o the cause(s)
	C T S	Σ	29b. Signature and title of certifier				icense number	2			signed (Month,	Day, Year)
	Da		20 11-10-10-		W (142 - 25 - 2		3657			/27/	06	
V	Kar Ne		30. Name and address of person who	TRWULTE	itn (Item 23a) (Typ	560 R	WEESIN	E D	R SAK	15	40 218	106
	Sta	ite	31. Date filed (Month, Day, Year)	32. Redistrar	s Signature	Societi.			1			-
	Registr	ar	JAN 3 0	2006	e B	Coares						

483-28-3727

E. MERCER

			For State Registrar	State of Maryland		artment of F			giene Reg. No.	06	04009
			1. Decedent's Name (First, Middle, Last			ب سنڌ		2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic	_	STEWART, C.	MCARTI	Hun-	971		01	29	2006	1751 M
_	Examin		4a. Facility Name (If not institution, give				r Location of Death		4c. Cou	nty of Death	
48.	3.	,35 <u>,</u>	UNIV OF MAN	ylans		TSALT If Under 1 Year	If Under 24 Hrs.	0.0		0.00	(0)
	Funeral Director		5. Social Security Number 6. Se 1383-38-4871	x 7. Age (In yrs. I	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Date		Mich	lace (State or Foreign
	*		Usual Residence of Decedent					7/13	/1939	IIICII.	igan
	ylanc how		10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	e Ma	cto	Mハ St. Mary'	s Mecl	nanics	ville					1 ☐ Yes 2,☐{No
	or 28	Director	10e. Street and Number	. 1		10f. Zip Code			10g. Citizen		
	death with the Maryland me 23a or 28a-f ahow Linual be nedling at	Funeral	37640 ASHE		S 112	206		anife Van an Na		S. A.	
_	iten de	-une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U. Armed Forces? 1 ∑Yes 2 ☐ No	5. 13.	If Yes, specify Cuba	fispanic Origin? (Spe an, Mexican, Puerto	Rican, etc.)		Black, White,	
2	hours after lurel', or ite	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates: 149-1	99	1 Yes 2X No	Specify:		Spe	city:	nite
2-003p	72 hours after death with the Marylan "natural", or Iteme 23a or 28a-f ahow idical Examinat haval be notified at	Completed	15. Decedent's Edu (Specify only highest grad	ication	16a. Dece	dent's Usual Decup	ation during most of work	ing	16b. Kind of	Business/In	
Z	within 7 ene. then "r	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	d)	ang			
Z	ygien ygien ygien th		12		Contr	actual En	D				Contractor
שב	be fill d ott	Be	17. Father's Name (First, Middle, Last) Stewart Coyles M	aAnthun In			18. Mother's Name	charlot			
Ĕ	d Mel d Mel mark matic	오	19a. Informant's Name/Relationship (7)		19h Maili	ng Address (Street	and Number or Rura				Code
<u>S</u>	nd 2 s Ith ar 27 ts r trau		Kathy Wolfe / Dau				rive Mech				
ē,	s 1 and f Healt item 2 other		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	Jan. 74 - 2000	Date		on - City or To	
aitimore,	if. Pages rtment of rtsnt: ff i njury or		1 Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)				tery Feb.	1,2006	Clinto	n, Mar	ryland
<u>a</u>	Departing mports any injustration		21. Signature of Funeral Service Licens	99	23	2. Name and Addre	ss of Facility Bri	nsfield	-Echol	s Funl	.Hme.,P.A.
n —	90 E E 9		Heren ( ) Sat		641 3	0195 Thre	e Notch R	d. Char	lotte	Hall,	MD 20622
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	ications that caused the death ne cause on each line.	n. Do not en	er the mode of dyin	ng, such as cardiac o	or respiratory ai	rrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. MULTIPLY	org.	AN FAIL	~~~				31307 4110 50411
	/Medical Examiner		resulting in country	Due to (or as a consequ	uence of):				2	$\supset$	10 days
i de		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequ	uence of j:				lety		
	uted d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	Motor 1	/e hicl	- Collis	· · ·	1 sol	V 7	9	
Ď,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a consequ	uence of):			X		EXAM	
8/PU	ate be ex hysician the buria	dical		d			X) 1	<i>/</i>	•EJICAL	, <u> </u>	
Q X	ding p	0	IF FEMALE:	23c. If yes, outcome of pregna	201		119		40 B		
ROX	death certificate e attending phys d for use as the	Physician/M	in the past 12 months?	1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)		APPR	~	Date of delive Month	Day Year
o.		ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown	Ja 02	3 0 (10) (0)000//		CATI			
٠, ح	The law requires thaf the de ite has been signed by the a page 2 should be detached f	by Pł	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	nderlying cause giv	ren in Part I.	23e. Did to	obacco use c	ontribute to th	ne cause of death?
ecords	w require been sig should b							10	Yes 2 No	3 Prob	pably 4 Unknown
ပ္သ	law re as be 2 sho	Completed						24a. Was			psy findings available mpletion of cause of
Ĩ		Con							rmed? 2 No	death?	2 □ No
Vital H	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Jan-Mali		104	26. Place of Deatl	h (Check only o	one)		
0	Phys this aldi	T0	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpaties 28b. Time o	nt 3□ DOA Oth	4 🗆 14d13l11g 110	me 5 Resident			y)
	ding P. Atte	tlon	1 ☐ Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	k? Yes 2. <b>∑</b> No	1/2	1	re laise	· Accident
DIVISION	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be	289. Place of Injuly - At no	دگا me, farm, st			28f. Location (S	Street and Nu	imber or Rura	al Route Number,
É	s afte	Certification:	4  Homicide determined	building, etc. (Specify	"Str-	cef	^	City or Ton	ZSUHE	RO/140	wow Itills a.
	To the Hospital or Attan within 24 hours after deat To the Funeral Director: completely filled in by the	edical (	29a. Certifier (Check only   Certifying Phy	sician: To the best of my kno iner: On the basis of examinat	wledge, deat	h occurred at the tir	me, date and place,	and due to the	cause(s) and	manner as s	tated. 2-0659
	To the H within 24 To the F complete	Medi	one)	and manner stated.	acti arta/of III						
	To To	Σ	29b. Signature and title of earlifier			29c. Licens			29d. Date sig	nea (Month,	uay, rear)
^			20 Nome and	GW 7	0201 77	(6	17 4		12	.100	
1	B 1591		30. Name and address of person who c	ompleted cause of death (Item  32. Redistrar's Signa  2006	alfin	ine M.	1 2120	1			
	Sta	te	31. Date filed (Month, Day, Year)	32. Resistrar's Signa	ture	1 4					
	Registr	ar	JAN 3 1	2006 Mesur	S. A	pare					

			For State	State of Ma	aryland		artment of H		nd Mental H	9	nns	nknin
			Registrar  1. Decedent's Name (First, Middle, La	ist)		001	tineate of L	Jean	2. Date of D	Reg. No.	. 0 0 0	3. Time of Death
	Physici		James Michael	·					Janua	ry 2		6:10 A M
1	/Medio Examir		4a. Facility Name (If not institution, give				4b. City, Town, or	Location of E		_	County of Deati	
	Zamiii	•	15100 Block of Mo	Kendree Ro	oad		Accokee	k		P	rince G	eorge's
	Funeral		5. Social Security Number 6. S	Sex 7. Ag 1. <b>X</b> M 2. □ F		ast birthday)	If Under 1 Year Months Days		Min. (Month, L	irth	9. Birtl	nplace (State or Foreign
	Director		219-00-0141	TIAM ZUF	21_	Yrs.			0ct. 1	5, 19	984 Mary	länd
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limits
	Mary!	tor	Maryland St. Mar	v ' s	G	reat N	4ills					1 ☐ Yes 2 <b>)</b> ☐ No
	1 the	rec	10e. Street and Number	, , , , , , , , , , , , , , , , , , , ,		ii ca o i	10f. Zip Code			10g. Citi	zen of What Co	untry?
	h with	by Funeral Director	22508 Iverson Dr	ive, Apt.	608A		206	534			USA	
	dee ms	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	S. 13. \	Was Decedent of His f Yes, specify Cubar	spanic Origin	? (Specify Yes or N	lo-	14. Race - Ame Black, White	
36	or it	y Fu	1 Never Married 2 Married	1 ☐ Yes 2 💢	No		1 ☐ Yes 2 🔀 No		,		Specify:	White
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural" or items 23e or 28e-f ehow ta Madigal Examiter must by invillad at	q p	3 Widowed 4 Divorced	Year or Dates:		100 Doors	dentin Liquel Ossura	tion		10h K	nd of Business/	advata.
5	in 72	Completed	(Specify only highest gr	ade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired;	uring most of	t working	100. KI	ila oi pasiliessy	ngustry
212	y with jiene.	mo	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Minir	ng			Sā	and & Gr	avel Co.
Þ	othe othe	BeC	17. Father's Name (First, Middle, Last	")				18. Mother's	Name (First, Middl	le, Maiden	Sumame)	
/lar	wid by Wents	To E	Kenneth T. Manis					Do	nna Jean	Powel	1	
Maryland	2 sho and I Is ma		19a. Informant's Name/Relationship				ng Address (Street a					
	and lealth m 27		Kenneth T. Manis	- Father	not Di		Rhodes I	Drive,	White PI	,		
00	ges 1 If of F If its or ot		20a. Method of Disposition 1 X Burial 2 Cremation 3 (		CE	emetery, crer	natory or other place				cation - City or	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-f ehow any injury or other traumatic event, the Medical Exprinter must be indified at ODGs.		4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice	•	111 00053		lemorial (					
Ba	Dermi Depa Impo eny Ir		Mark HB	a house	,		untt Fune				vashingt MD20601	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death						1.02000	Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as	-	uence of):						<del></del>
Н	Examiner	_	Sequentially list conditions,	b								
	pe #8	ine	cause. Enter Underlying Cause (Disease or injury	Disa to (or as	a nonsaqu	ience of):						
	cate be executed physicien end the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a consequ	ience of):						
8760,	siclen buris	dicai E		d								
9	ificate g phy as the	edic										
Вох	leath certific: attending pl	M/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth	of pregnar	ncy	Ectopic pregnancy			l i	23d. Date of deli	very
	deat ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (specify)				Month	Day Year
P.O.	res thet the death signed by the atter be detached for t	Phy	9 Unknown									
	The law requires thet the death certificate be executed ate has been signed by the attending physicien end bage 2 should be detached for use as the burial-transit	Completed by Physician/Med	Part II. Other significant conditions	contributing to death b	ut not resu	ilting in the ui	nderlying cause give	in in Part I.			No 3 Pr	the cause of death?
of Vital Records,	w requir been si should	eted										
360	has l	mpi							— 24a. Wa	is an opsy formed?	prior to death2	topsy findings available completion of cause of
a			05 111	,				-	1 🖫 Yes	2 No		2 No
₹	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  ↑ ↑ ↑ ↑ No	Hospital:	م مات	ER/Outpatien	othe		Death Check only	-	0. TOther (0	4) 0
o	<b>ਦ</b> ≑ ਢ	7: To	27. Manner of Death	28a. Date of Inju (Month, Da		28b. Time of			ing Home 5 Re			Scene
ion	Attending r death. •ctor: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation	1	۷	5:50		? ′es 2⊠No	pewon	OFU	DRINGA	UNWITHTREE
Division	Attendi	Certification:	3 Suicide 6 Could not be determined		ury - At ho	me farm str	eet, factory, office		28f. Location		d Number or Ru	ral Route Number,
۵	tel or rs afte el Dir led in l	Cer		building, et	0100	Lan					ROBER	NOYWING 410
	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	edicai	(Check only 2 Medical Exa	hysicien: To the best miner: On the basis of	f examinat	wledge, death ion and/or in	occurred at the time vestigation, in my op	e, date and pointion, death	place, and due to the	e cause(s) e, date and	and manner as place, and due	stated. to the cause(s)
	thin 2 the mplet	Med	29b. Signalture and title of certifier	and manner sta	ated.		29c. License				e signed (Mont)	
	₽ ¥ ¥ 5 8		11014	1 11.6	10	MID						
0			30. Name and address of person who	completed cause of d	leath (Item	23a) (Tune		CME		Janu	ary 28,	2006
1	DB.3		MAN2412mm	D KORE		Lou, (Type,	111 Per	nn Str	eet Balt	imore	e, Maryl	and 21201
Ì	Sta		31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ture! A	parle				<u> </u>	
	Reaistr	ar_	1 1 1 1 1 1	/IIIID AND	Mary .	- //						

Baltimore, Maryland 21215-0036 Gladys McGregor

Division of Vital Records, P.O. Box 68760,

Genes is HealthCare — The Pines  Genes is HealthCare — The Pines  Special Security Number   6. Sex   40. Celly, Town, or Location of Death   40. Celly, Town, or Location of Death   40. Celly, Town, or Location of Death   40. Celly, Town, or Location   40. Celly, Town, or Locatio	-	State Registrar		C	ertificate of	Death		Rag. N	. 000	U4U11
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A Early Name (First installating, give street and number)  Generals & Health Charac — The Pines  Saston  1		GLADYS LILLI	AN MCGREGO	R			_			5:40 AM
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19. Motifor's Name (First, Middle, Maildon Surname)   19. Motifor's Name (First, Middle, Maildon Surname)   19. Motifor's Name (First, Middle, Maildon Surname)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   19. Mailing Address (Street and Number or Pural Place)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code Nu	<u>~</u>	1 Never Married 2 Married	Armed Forces? 1 X Yes 2 □ No If Yes, Give		If Yes, specify Cub	an, Mexican, F	n? (Specify Yes or Puerto Rican, etc.)	No-	Black, Whit	e, etc.
19. Michar's Name (Frist, Middle, Mailden Sumanne)				16a. De	cedent's Usual Occup	oation		16b. l	Kind of Business	/Industry
19. Mother's Name (First, Middle, Mailden Surname)   19. Mailing Address (Street and Number or Pural Route Number, City or Town, State 20 Code)   10. Mailing Address (Street and Number or Pural Route Number, City or Town, State 20. Date   10. Mailing Address (Street and Number or Pural Route Number, City or Town, State 20. Date   10. Mailing Address (Street and Number or Pural Route Number, City or Town, State 20. Date   10. Mailing Address (Street and Number or Pural Route Number, City or Town, State 20. Date   10.	2			life	ve kind of work done . DO NOT use retire	auring most o d)	or working			
19. Mother's Name (First, Middle, Mailden Surname)   19. Mother's Name (First, Middle, Mailden Surname)   19. Mother's Name (First, Middle, Mailden Surname)   19. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 20 Code)   10. Mailing Address (Street and Number or Pural Ploute Number, City or Town, State 1.0 Date   20. Location   20. Place of Disposition (Name of the Place)   21. Signature of Pural Place   21. Signature of Pural Place   22. Name and Address of Place   21. Signature of Pural Place   22. Name and Address of Place   22. Na	5		-	.	GISTERED N	URSE		PU	BLIC HEA	LTH
19a. Informants Name/Relationship (Type, Print)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19a. Informants Name/Relationship (Type, Print)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19a. Informants Name/Relationship (Type, Print)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Pural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  19b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address (Sireet and Number or Rural Route Number, City or Town, State, Zip Code)  10b. Mailling Address of Easterna Number or Rural Route Number or Rural Rou		17. Father's Name (First, Middle, Last)				18. Mother's	s Name (First, Mid	dle, Maide	n Surname)	
19a. Informants Name/Relationship (Type, Print)  BETTIE TABB FORSTER/NIECE  20a. Method of Disposition Higherial 2   Certifying Phase Higherial 2   Certifying Physician: To the best of Imparity of Chief (Specify)  20a. Method of Disposition Higherial 2   Certifying Physician: To the best of Imparity of Chief (Specify)  20b. Place of Disposition (Name of cemeriary of chief place) 20c. Location - Clify or Town, State 20c. Location - Clify or Location - Clify or Town, State 20c. Location - Clify or Location - Clify or Location - Clify or Town, State 20c. Location	0	JOHN S. MCGREGOR				RENA	REESE			
20a. Nighthod of Disposition 12 Burial 2   Cremation 3   Removal from State   12 Burial 2   Cremation 5   Chem (Speorly)   12 Is Signature of Funeral Service Licensee   13				19b. Ma	iling Address (Street	and Number	or Rural Route Nu	mber, City	or Town, State, 2	Zip Code)
## Burial 2   Cremation 3   Removal from State   RIDGELY CEMETERY   2/2/2006   RIDGELY, MD    21. Signature of Funeral Service Licensee   22. Name and Address of Facility   FELLOWS   HELFERBEIN & NEWNAM FUNERAL    22. Name and Address of Facility   FELLOWS   HELFERBEIN & NEWNAM FUNERAL    23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interval disease or condition resulting in death)    23. Due to (or as a consequence of):  23. By the standard of the significant conditions contributing to death but not resulting in the past 12 moghts?    23. If yes, outcome of pregnancy   1   Live birth 2   1   Festal death    23. If yes, outcome of pregnancy   1   Live birth 2   1   Festal death    23. If yes, outcome of pregnancy   1   Live birth 2   1   Festal death    23. If yes, outcome of pregnancy   2   2   2   2   2   2   2   2   2	1	BETTIE TABB FORS	TER/NIECE	710	WEST LOS	LAGOS	VISTA AV	E., M	ESA, AZ	85210
22. Name and Address of Pacific Completions and Address of Pacific Completion of Pacific		1 Buriat 2 ☐ Cremation 3 ☐		cemetery, c	rematory or other pla					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Immediate Cause (Final disease or condition resulting in death)	T	21. Signature of Funeral Service Licen	see	~ I	22. Name and Addre	ss of Facility	EIN & NE	WNAM	RIINERAT.	
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Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a		shock, or heart failure. List only	one cause on each line	i. Ne deatri: Do not e	anter the mode of dyl	ng, such as ca	ardiac or respirator	y arrest,		Interval Between Odset and Death
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Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a consequence of persons.   Due to (or as a consequence of delivery.   Due to (or as a consequence of):		resulting in death)	Due to (of as a	consequence of):	1			/	1	0
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Due to (or as a consequence of):    Due to (or as a consequence of):   Due to (or as a	lue l	if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):	E.					(
IFFEMALE:   23b. Was decedent pregnant in the past 12 months?   1   Live birth 2   Fetal death 4   Pregnant at time of death 5   Other (specify)	саш	that initiated events	C							
23b. Was decedent pregnant in the past 12 months? 1   2   Fetal death   3   Ectopic pregnancy   Month   Day    23d. Date of delivery   Month   Day    24d. Was an autopsy find prior to completion death?    24a. Was an autopsy find prior to completion death?    25d. Place of Death (Check only one)    25d. Manner of Death   Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other:   Nursing Home   5   Residence   6   Other (Specify)    27d. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28d. Date of Injury   28d. Describe how injury occurred    28d. Date of Injury   28d. Describe how injury occurred    28d. Date of Injury   28d. Describe how injury occurred    28d. Date of Injury   28d. Describe how injury occurred    28d		rossing in soun, cast	Due to (or as a	consequence or):						
23b. Was decedent pregnant in the past 12 mochs? 1 lowe birth 2 field death 4 pergnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 pregnant at time of death 9 lower field death 4 lower fi	Ca	•	d							
23b. Was decedent pregnant in the past 12 moghs? 1   1   Live birth 2   Fetal death 4   Pergnant at time of death 9   Unknown	Mec	IF FEMALE:								
25. Was case referred to medical examiner?  1   Yes   2   No   3   Probably   4    26. Place of Death (Check only one)  27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)    28. Date of Injury   28b. Time of Injury   Nursing Home   5   Residence   6   Other (Specify)    29. Certifier   Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	$\rightarrow$	23b. Was decedent pregnant	1 Live birth 2	Fetal death		y				
238. Did tobacco use contribute to the cause of the underlying cause given in Part i.  24a. Was an autopsy performed prior to completion death?  25. Was case referred to medical examiner?  1   Yes   2   No   1   Yes   2	SC	1 ☐ Yes 2 ☐ No						-	MOUTH	Jay redi
24a. Was an autopsy performed?    24a. Was an autopsy performed?   24b. Were autopsy find prior to completion death?   24b. Were autopsy find prior to completion death?   25c. Place of Death (Check only one)   25c. Place of Death (Check only one)   26c. Place of Death (Check only one)   27c. Manner of Death   28a. Date of Injury   28b. Time of   28c. Injury at   28d. Describe how injury occurred   28d. Describe how injury	Ē									
24a. Was an autopsy finding performed to medical examiner?  25. Was case referred to medical examiner?  1   Yes   2   No   24b. Were autopsy finding prior to completion death?  26. Place of Death (Check only one)  27. Manner of Death   Nursing Home   5   Residence   6   Other (Specify)  28a. Date of Injury   28b. Time of Injury   28b. Time of Injury   28c. Injury at   28d. Describe how injury occurred   28d. Describe how i	þ	ran ii. Other significant conditions c	ontributing to death but	not resulting in the	underlying cause giv	on in Part I.			_)	
25. Was case referred to medical examiner?  1   Yes   2   No							- 1	⊔Yes 2	ruerno 3∐Pr	obably 4 Unknow
25. Was case referred to medical examiner?  1	pie									
25. Was case referred to medical examiner?  1   Yes   2   No	6						_ pe	arformed2	death?	
1   Yes 2   No		25. Was case referred to medical				26. Place of			1 100	
27. Manner of Death   Natural   S   Pending   Injury   At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route of Linguity one)		examiner?	Hospital:	2 □ EB/Outpat	ent 30 DOA Oth	ner /			6 □Other (See	cifu)
Matural   2   Accident   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Matural   5   Pending investigation   3   Suicide   4   Homicide   4   Homicide   4   Homicide   4   Homicide   4   Matural   5   Pending investigation   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route   City or Town, State)   29a. Certifier (Check only one)   4   Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	1		28a. Date of Injury	28b. Time	of 28c. Injur	ry at			- 1-7	<i>∪⊓y</i> /
29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of t	LIOI		(Month, Day	Year) Injur	Wo	rk?		,		
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Ca	3 ☐ Suicide 6 ☐ Could not be		y - At home, farm		-		n (Street a	nd Number or Ri	ural Route Number
29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause of t	E	4 Homicide determined	building, etc.	(Specify)						
(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cau and manner stated.		29a Certifier Cartifuing Dh	vsician: To the best of	my knowledge do	Ath occurred at the 15	me date and	place, and due to t	he causals	and marror or	stated
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Yes)  27/-06	Ca	(Check only 2 Medical Exam	niner: On the basis of e	xamination and/or	investigation, in my	me, date and p opinion, death	occurred at the tin	ne, date an	o, and manner as nd place, and due	to the cause(s)
1985 MS DZ5750 2-1-06	Me		Name of State	. )	29c. Licens	se number		29d D	ate signed (Mont	h. Dav. Year)
17/1/		1000	W IM	2	A 7 S	-71-1	)	7	-1-17/	., 20, 100/
		100	- 0,,,		000	11 (		1	1 06	•
30 Name and address of person who completed cause of death (Item, 23a) (Type, Print)		30 Name and address of person who		ath (Item 23a) (Typ	e, Print)	Λ.	, ) r	100		010 -
KOBERT SANCHEZ MD 508 TOLEWILD HVENUE LASTON MD 2  10 31. Date filed (Moorn Pay Year) 2000 37 Aegistrar's Signature		KOBERI DANCI	165 1,117	JUS 7	DUEWILD	HVEN	JUE L	17570	CM 1110	21601

Registrar

		For State Registrar Decedent's Name (First, Middle, La	st)	Certificate of	Deaiii	2. Date of Deat Month	eg. No. th Day Year	3. Time of Death
ysician ledical		Ruth Jane Maxv	vell			Feb	2 2006	M
aminer	4a	Facility Name (If not institution, give			or Location of Death		4c. County of De	ath
	_	Genesis Healtr Social Security Number 6.5	iCare - The Pir		aston If Under 24 Hrs.	9 Date of Birth	Tal	
eral ctor		220-52-8948	□ M 2 X F 96	Yrs. Months Days	Hours Min.	8. Date of Birth Month, Day, 5 – 4 –	909 De	inthplace (State or Foreign Dountry) Laware, OI
<b>a</b>	10	sual Residence of Decedent  Da. State 10b. County		wn or Location				10d. Inside City Limits
cto	M	d Talbot	St. M:	ichaels				1 □ Yes 2X No
Dire	10	e. Street and Number		10f. Zip Code		11	0g. Citizen of What (	Country?
iner , ust be notified	9	29 Riverview S	12. Was Decedent Ever in U.S.	21663	dienania Origin? (Sa	acifu Vac or No.	USA	nerican Indian,
À		Marital Status     1 □ Never Married 2 ☑ Married     3 □ Widowed 4 □ Divorced	Amed Forces?  1 Yes Moly No If Yes, Give Year or Dates:	13. Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 🛣 No		Rican, etc.)	Black, Wh	ite, etc.
t, the Molecul Completed		15. Decedent's E (Specify only highest gr	ade completed)	a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	pation during most of worki	ing	16b. Kind of Busines	s/Industry
a mo		12 years	College (1-4or 5+)	ecretary-T			Auto dea	ler
Be C	17	7. Father's Name (First, Middle, Last			18. Mother's Name			
		William H. Wil		E Martin Address (Osses	Maude S		City Town City	Tie Code)
traur		9a. Informant's Name/Relationship ( Virqil W. Maxv	vell (husband 9	b. Mailing Address (Street 929 Riverv				
other traumatic		a. Method of Disposition						
iry or		1 ☐ Burial 2X Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State Capi	of Disposition (Name of ery, crematory or other pla tol cremat	ory 2-6-	2006 D	over, De	•
any injury or other		1. Signature of Funeral Service Lice	, / // //	R. Carro	ass of Facility II Hurle	y Fune:	ral Home	,PC
	2	3a. Part 1. Enter the disease, or com	plications that caused the die th. Do one cause on each line.	P. O. Po	x 518, S	t. Mich	hacls, M	d.21663
ian	. Ir	nmediate Cause (Final	one cause on each line.	mather				
ical		isease or condition esulting in death)	a. Due to (or as a consequence	of):				months
ner	S	equentially list conditions.	b. Hyperting	ston.				neers
iner	if	equentially list conditions, any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to (of as a consequence	of):				hears
Examiner	th re	nat initiated events esulting in death) Last	c. Due to (or as a consequence	of):				Jeans
as the buri		(	d					
use as		FEMALE: 3b. Was decedent pregnant	23c. If yes, outcome of pregnancy				23d. Date of d	elivery
should be detached for use as the burial-transit feted by Physician/Medical Examir		in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 Fetal deat 4 Pregnant at time of death 9 Unknown	th 3 □Ectopic pregnanc 5 □ Other (specify) _	y 		Month	Day Year
be det	Pa	$\Omega$ 1	contributing to death but not resulting	in the underlying cause gi	ven in Part I.			to the cause of death?
hould	-	<i>िर्मु श्रुवान्य</i>	1 + 2	. /2			1	
CI D	1-	Chrome obs	tradive pulmona	my diseuse	<del></del>	24a. Was a autops perform	y prior to	autopsy findings available completion of cause of
So So		5. When some softened to modical				1 ☐ Yes 2	2 <b>X</b> No 1 □ Y€	es 2 No
		5. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Outpatient 3 DOA Ott	26. Place of Death		ence 6 □Other (Sp	necify)
0	1	7. Manner of Death		Time of 28c. Inju	ry at		ow injury occurred	
The run		Natural 5 Pending 2 Accident investigation	n		Yes 2□No			
Certification:		3 Suicide 6 Could not to determined		farm, street, factory, office		28f. Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
≝ 2		9a. Certifier (Check only one)  1 Certifying Place   Certifying Place	nysician: To the best of my knowledge miner: On the basis of examination a and manner stated.	ge, death occurred at the ti and/or investigation, in my	me, date and place, opinion, death occurr	and due to the cared at the time, da	ause(s) and manner ate and place, and di	as stated. ue to the cause(s)
dica		9b. Signature and title of certified	V. A	29c. Licen:	se number	000	9d. Date signed (Mor	
completely filled in by the funeral Medical Certification: 1	-   2							
completely	2	> SHR	rendypo		7259	13)	2.2	06
t completely Medica		D. Name and address of person who	C. C. C.		17299 IAN'S KANG	1 50	Z.Z	21601

PRIVACION PROCESSOR LEVI   1.0 months of price (Asses) LEVI   1.2 months of price (Ass				1 - State State Registrar	of Maryland / D	epartment Certificate			giene Beg. No.: 006	04013
ELEANOR MARLENS MARCON ROLL AND STATE AND STAT								2. Date of Dea	ath	3. Time of Death
FreeDerick Memorian   Hospital   Freederick Memorian   Hospital   Freederick Memorian   Hospital   Freederick Memorian   Hospital   Freederick   F				ETEANOD MADI	ENIE MADUZ					1.35 A M
Prederick Memorial Hospital   10 to 20 m	1						wn, or Location of			1.00 11
1.	1	LAGIIII		Frederick Memorial Hosp	oital	Free	derick		Frederic	ζ
Use Flavorous of Decident  102. Size   100. Cores   100.		Funeral		Social Security Number 6. Sex		hday) If Under 1	Year If Under 2		th 9. Birthp	place (State or Foreign
Top Size	п			214-34-0091 1DM 2DF	70 Y	rs. Months	Jays Hours	Dec. 2	7, 1935 Mary	land
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)		pu >			10c City Town	or Location				Od Inside City Limits
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)		ehov	<u>_</u>	,						
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)		28a-1	ect		Walke		odo		10a Citizon of What Cour	X
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)		with a or	눕							my:
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)		eath	eral		cedent Ever in U.S.			in? (Specify Yes or No		can Indian.
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)	10	fer d	표	1 Never Married 2 Married 1 Yes	orces?			Puerto Rican, etc.)	Black, White,	etc.
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)	036	urs a	by	3 ☐ Widowed 4 ☐ Divorced If Yes, 0 Year or	Bive Dates:	1 □ Yes 2X	No Specify:		Specify: Wh	ite
College (1-4or 5+)   Homemaker   Name (First, Middle, Last)   Walter W. Poole   Homemaker   Name (First, Middle, Masder) Summer)   Myrttle Ramper (First, Middle, Masder)	Õ	2 ho	ted	15. Decedent's Education	16a.	Decedent's Usual	Occupation	of working	16b. Kind of Business/In	dustry
Physician Medical Examiner  Ph	215	thin 7	nple.		(1-4or 5+)	life. DO NOT use	retired)	or working		
Physician Medical Examiner  Ph	2	ed wi	ပ္ပ			Homemak				
Physician Medical Examiner  Ph	nd	d oth	Be						Maiden Sumame)	
Physician Medical Examiner  Ph	<u>Y</u>	ould Men Marke Marke	ို		1.00	44.11. (				0.7-1
Physician Medical Examiner  Ph	Mai	d 2 sh th and 7 is n traun								
Physician Medical Examiner  Ph		1 and Healt		20a. Method of Disposition	20b. Place of	Disposition (Name	of			
Physician Medical Examiner  Ph	ē	ages ent of ht: If II			n State			/31/06	Frederick. M	arvland
Physician Medical Examiner  Ph	Ħ	mit. F partme ortar Injur			2	-,-				
Physician Medical Examiner  Ph	ä	De de la company		Collection that	21/9					
Physician (Mactical Examiner)    Mactical Examiner   Mactical Examiner				23a. Part1. Enter the disease, or complication, that	s one death. Do n					
Due to (or as a consequence of):    Due to (or as a consequence of):		Physician	0. 3	Immediate Cause (Final	Prance la	-a-fin 1	O dias	111-11-11-	2:	Onset and Death
Social field is a consequence of the constraint				resulting in death)	o (or as a consequence of	of):	uvalov	ascular	VISEASE	years
The standing in death) Last    Column	н	Examiner		D. D						,
The standing in death) Last    Column		n =	ner	if any, leading to immediate Due to cause. Enter Underlying	o (or as a consequence o	of):				
Section   Sect		nd ransi	ami	that initiated events						
FFEMALE:   23b. Was deedent pregnant in the past 12 months?   1   1   ves   2   Show   1   ves   1   ves   2   Show   1	90,	oe exe	Ä	Due t	o (or as a consequence o	of):				
The state of the s	87	cate to physic	dlca	d						
The state of the s	×	ding	/Me	230 II VAS 0	utcome of pregnancy				23d Date of deliv	90/
The state of the s	Bo	atten for u	clan	in the past 12 months?	birth 2 Fetal death					•
The state of the s	o.	the d y the	lys		nown					
The state of the s		s that ned b s deta	y P	Part II. Other significant conditions contributing to	death but not resulting in	the underlying cau	se given in Part I.	23e. Did t	obacco use contribute to t	he cause of death?
25. Was case referred to medical examiner?  1	rds	quire n sig uld b	De De	Hypertension				10'	Yes 2 No 3 ☐ Prol	bably 4 □Unknown
25. Was case referred to medical examiner?  1	တ္တ	s bee	plet	Chrebellar 1	Deaene	ration	7		an 24b. Were auto	ppsy findings available
25. Was case referred to medical examiner?  1	ä	The I	E	Sensis				perfo	ormed? death?	
29a. Certifier (check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	ita		0				26. Place			<u> </u>
29a. Certifier (check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	<b>†</b> \	nysic nis ce direc	2	Hospital:	Inpatient 2 ER/Out	tpatient 3 DOA	Other: 4 Nur	sing Home 5 Resid	dence 6 □Other (Specia	(y)
29a. Certifier (check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	0	ng Pt fter th		27. Manner of Death 28a. Dat	e of Injury 28b. T onth, Day Year) In		: Injury at Work?	28d. Describe I	how injury occurred	
29a. Certifier (check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Sio	eath. or; A	catl	Accident investigation						
29a. Certifier (check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	Σ	or Att	=	determined 286. Fld	ce of Injury - At home, far ding, etc. <i>(Specify)</i>	rm, street, factory,	office	28J. Location (: City or To	Street and Number or Run wn, State)	al Route Number,
State Registrar		pital ours a erai [	ဝီ	20a Cartifier Cartifying Physician: To t	he heet of my knowledge	death accurred at	the time date and	I place, and due to the	cource(s) and manner as a	tated
29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  Registrar  31. Date filed (Month, Day, Year)  32. As (strar's Signature)  AN 3-1 2006		e Hos 24 hr Fun e Fun	dlca	(Check only 2 Medical Examiner: On the	basis of examination and	d/or investigation, in	my opinion, death	n occurred at the time,	date and place, and due t	o the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  32. Refistrar's Signature,  AN 3-1 2006		within To th comp	Me	29b. Signature and title of certifier		29c.	License number		29d. Date signed (Month,	Day, Year)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State Registrar  31. Date filed (Month, Day, Year)  32. Refistrar's Signature  Registrar				Illan Kolv	zes. Mr		371	97	1-30-2	2006
State Registrar  31. Date filed (Month, Day, Year)  32. Refistrar's Signature Registrar		M		30. Name and address of person who completed ca	use of death (Item 23a) (	Type, Print)	, -11	12 ,		141-
State Registrar  31. Date filed (Month, Day, Year)  32. Refistrar's Signature  Registrar		10		HIGH KOHYEN	MD.	15 Wes	1/14	Street	redevil	EMD ZI70
				IAN 3.1 2006	Allegar &	Aprile				

		•	For State Registrar	State of Ma	arylan				lealth a		ş	Reg. No.	06	04014
		d	1. Decedent's Name (First, Middle, Las	t)							2. Date of Dea Month Februa		2006	3. Time of Death 8:50A M
	Physicia /Medic	al.	Margaret Lambe		son	McGee					rebrua			
1	Examin	_	4a. Facility Name (If not institution, give				4b. City,		Location of				ounty of De Carro	
		pi-	Summerville at W			last birthday)	If Unde	r 1 Year	tmins!		8. Date of Birt			
	Funeral Director		216-03-9204		90		Months		Hours	Min.	Nov. 3	0, Year 19	15 Ma	irthplace (State or Foreign Country) ryland
	and	-	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ocation							10d. Inside City Limits
	e Maryl	ctor	Maryland Carr	011			T		tmins	ter		10- 6%-	4 10 (5 - 4 (	1X Yes 2 No
	or 26	Dire	10e. Street and Number	- D-d			10f. Zij	Code	01157			10g. Citize	on of What (	
	ath w	rai	45 Washingto	n Ko.	Cues in 11	6 12	Mac Door		21157	ain? (Spec	thy Ves or No	. 14	U.S.	nencan Indian,
36	72 hours after death with the Maryland natural; or Iteme 23a or 28a-f ehow dical Examiner must be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	Armed Forces?  1 Yes 2 1 if Yes, Give Year or Dates:		.3.	If Yes, spe				ofy Yes or No Rican, etc.)		Black, Wh	
21215-0036	72 hours "natural", dical Exa	ted	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occup	ation	t of workin	0	16b. Kind	d of Busines	ss/Industry
215	within 7; ene. than "n	pie	(Specify only highest gra	College (1-4or 5	5+)				during mos d)		g	sewin	g	
21	giene giene er thu	Completed	11			seams	stres	s/ h	omema			facto	-	own home
р	be filed tal Hygie d other event, t	Be (	17. Father's Name (First, Middle, Last)								(First, Middle.		umame)	
yla	2 should be to and Mental it is marked or raumatic eve	မ	Maland S. Lamber								bertso		Town Canal	Tin Code)
Maryland	permit. Peges 1 and 2 should be filed within 72 hours Department of Health and Abnial Hygiene. Important: If Item 27 is marked other than "natural", any injury or other traumatic event, tha Publical Example.		19a. Informant's Name/Relationship ( Gene Fleming/ nep						Blvd.		Route Number,			
	tem 27 tree tree		20a. Method of Disposition		20b. F	Place of Disponentery, cre	osition (Na	me of	ce) I	Da	ate	20c. Loca	ation - City	or Town, State
Baltimore,	permit. Peges Department of t important: If ite any injury or of		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State  /)		nters			1	2/7/2	2006	New	Winds	or, MD
ij	antinion injuries		21. Signature of Funeral Service Licer							∀Hart	zler F	unera	1 Hom	ie
ñ	Depa impo any ir		* 100040 7. 15	10thers			310 C	hurc	h St.	N	lew Win	dsor,	, MD 2	21776
PK.	Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	aES	pl	16900	1		ng, such as		respiratory a	rrest,		Approximate Interval Between Onset and Death
0,	ate be executed nysicien and he burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	C Due to (or as										
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.O. Box 68	The law requires that the death certifica sie has been signed by the attending ph page 2 should be detached for use es it	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 € No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Feta	al death 3	□Ectopic		у			23	3d. Date of o	defivery Day Year
Ω.	ires that t signed by d be detai	d by Ph	Part II. Other significant conditions of	ontributing to death b	out not res	sulting in the	undertying	cause gr	ven in Part	1.	111	tobacco us	_	e to the cause of death?  Probably 4 Unknown
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>		ToB	examiner? 1 ☐ Yes 2 XNo	Hospital:	ent 2	ER/Outpatie	ent 3 🗆 🛭	Ot Ot	her: 4 🗆 N	ursing Hor	ne 5⊡Res	idence 6	Other (S	n
n of	ding Phy h. After thii funeral c		27. Manner of Death 1,≅Natural 5 □ Pending	28a. Date of fnju (Month, Da	ury ay Year)	28b. Time Injury	of M	28c. Inju	ryat ork? ]Yes 2[		28d. Describe	how infury	occurred	Living
Division	i or Attending latter death. Director: After din by the funer	Certification:	2 Accident investigatio 3 Suicide 6 Could not b 4 Homicide determined	B 200 Place of In	jury - At h tc. (Speci	nome, farm, s			1163 2		28f. Location City or To	(Street and own, State)	l Number or	r Rural Route Number,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best miner: On the basis of and manner st	of examin	ation and/or	nvestigatio	n in my	oninion de	ath occurre	ed at the time	. date and	place, and (	due to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier				2	9c. Licen	se number			29d. Date	signed (M	onth, Day, Year)
			fulle	16 M	0			DE	2058	313	7	- 7	2/3	16
_	Ja 10		30. Name and address of person who	completed cause of	death (Ite	m 23a) (Type	Print)	30	2	1,100	7 tonit	cho	M	0 21157
	St		31. Date filed (Month, Day, Year)	32. Re 2	rar's Sign	ature	Local	Re)		N 1 - 3				

			1 - For State Registrar	ate of Marylar		artment of H			giene Reg.No.00	6 04015
		3	Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3, Time of Death
20	Physici /Medic		Elmer Jacob	Mease	11			Februar	y 5 2	ở%6 2:43P м
1	Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or		eath	4c. County of	
4		ili Silita	Frederick Memorial H			Freder				ederick
	Funeral Director		5. Social Security Number 6. Sex 215-36-6779 6. Sex	7. Age (In yrs	, .	If Under 1 Year Months Days	If Under 24 H Hours M	8. Date of Birt in. Aug • 2	7, Year 911	9. Birthplace (State or Foreign Mary and
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	f aho	ō	Maryland Frederic	:k		Woodsbo	ro			1 ☐ Yes 2 🔀 No
	28e-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of W	/hat Country?
	h with		12115 Oak Hill Rd				21798		U	I.S.A.
	deat	Funerai	11. Marital Status 12. W	as Decedent Ever in U	J.S. 13.	Was Decedent of Hi	spanic Origin? n. Mexican, Pu	(Specify Yes or No- ierto Rican, etc.)	14. Race	e - American Indian, k, White, etc.
98	or Its		1 Never Married 2 Married 1 (	∃Yes 2 <b>X</b> ∃No Yes, Give		1 ☐ Yes 2X No		, , , , , , , , , , , , , , , , , , , ,	Specify:	
215-0036	72 hours after death with the Maryland natural', or Itama 23a or 28e-f ahow disal Examinar must be notified at	d by		ear or Dates:	16a Dasa	danila Havel Occupa	ting		16b, Kind of Bu	WIIILE
15	n 72 nat	Completed	15. Decedent's Education (Specify only highest grade com		(Give	dent's Usual Occupa kind of work done of DO NOT use retired,	turina most of i	working	16b. Kind of 8u	siness/industry
212	filed within Hygiene. Ither then "	m o	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)		farmer			dairy	& crop
b	e filed Il Hyg other	BeC	17. Father's Name (First, Middle, Last)					Name (First, Middle,		θ)
/lar	Venta Wenta rrked rrked	TOE	Harvey E. Measell				Anna	Virginia	Keller	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural; or Itama 23a or 28e-1 ahow any injury or other traumatic avent, the Madical Examiner must be notified at ance.		19a. Informant's Name/Relationship (Type, Pi			ng Address <i>(Stre</i> et a		Rural Route Number	er, City or Town, S	_
	1 and lealth om 27 ther to		Robert E. Measell/ so					Date		City or Town, State
Baltimore,	ages nt of the Hite	111	1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov	ai irom State		osition (Name of matory or other place Cemetery	a) 2/	8/2006	Woodsbo	
Ë	iit. Partmer artmer artent injury		4 Donation 5 Other (Specify)  21. Sign three if Fundral Service Licenses	1///		·	1	Hartzler		
Ba	Departiment of the sany is		atharine .	Day Zle	$\sim$ $_{1}$	104 S. Mai	n St.	Woodsbo	ro, MD 2	1798
			23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	is that caused the dea	ath. Do not en	ter the mode of dying	g, such as card	diac or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Ac. Vo	11.	cordina	11	arcilia		Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence di);	CO-7 . 9 . 7 (A) /	-/ ^ / 4	<i>y</i> , (, )		
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0.0	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	iquence or):					
	secut and al-trar	Examiner	that initiated events c	Due to (or as a conse	quence of):					
8760,	requires that the death certificate be executed been signed by the attending physicien and hould be detached for use as the buriat-transit									
9	ufficati g phy as the	ledic								
Вох	endin r use	N/UE	236. was decedent pregnant	yes, outcome of pregr □Live birth 2 □ Fe		Ectopic pregnancy				e of delivery
	that the death certific ed by the attending p detached for use as t	Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☐ No	Pregnant at time of Unknown		Other (specify)			Mor	nth Day Year
P.0	d by t	Phy	9 Unknown  Part II. Other significant conditions contribut	ing to death but not re	sulting in the	inderlying cause give	en in Part I	23e. Did to	obacco use contr	ribute to the cause of death?
ds,	signed to det	d by	Tarrit. Other signment of the second	ing to dodar but not re	Juliang III and t	andony my oddoo give	5. THE TOTAL ST.	10	res 2 No	3 Probably 4 Unknown
Sor		ete						24a. Was	an 24b. V	Were autopsy findings available
Vital Records,	a sic	Completed						- autor	rmed?	orior to completion of cause of death?
ta	Physicien: The I this certificate ha ral director, page	0	25. Was case referred to medical				26. Place of	1 ☐ Yes Death (Check only o		Lifes 2Lino
N N	Physicien: this certific ral director,	To B	examiner?	al: 1 Inpatient 2	R/Outpatie	nt 3 DOA Othe	ar:	ig Home 5 ☐ Resi		ar (Specify)
n of	ding Ph h. After th funeral		27, Manner of Death  1 Natural 5 Pending	a. Date of Injury (Month, Day Year)	28b. Time o	of 28c, Injun World	/ at k?	28d. Describe	how injury occurr	ed
Sio	Attending r death. ector: After by the fune	catic	2 Accident investigation		Ni.		Yes 2 □ No			
Division	or Att	Certification:	3 Suicide 6 Could not be determined 28	e. Place of Injury - At building, etc. (Spec	home, farm, st cify)	reet, factory, office		28f. Location (S City or Tox		er or Rural Route Number,
	pltel ours a herel I		29a. Certifier Certifying Physician	: To the best of my kr	nowledge dea	th occurred at the time	ne date and pi	ace, and due to the	cause(s) and ma	inner as stated.
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	(Check only 2 Medical Examiner: 0							
	To th To th comp	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date signed	d (Month, Dey, Year)
	- 0		* Heulh	M)		D310	58		2/6/20	06
	Mary		30. Name and address of person who comple					Joodshass	MD 217	98
	7 7		Gene Ashe	1020 32. Regist f's Sign		ermine Rd	. \	Woodsboro	, MU ZI/	Ju
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) FEB 0 7 2	06 Messes	in the	boute				

Landis M. McNally Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-0831 State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. UU 6 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 **Physician** Landis Mary McNally February 9:02 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cumberland Allegany Memorial Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 □ M 202 F 215-15-5368 22 Director May 20 1983 W. VA Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County or than "naturel", or iteme 23a or 28a-f show the Medical Examiner must be notified at 1 Tyres 2 □ No Director MD Carroll Union Bridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21791 USA 114 S. Main Street Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ≥ ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) N/A N/A N/APages 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental Hitem 27 is marked of rother treumatic ever Anjela Roderick ဥ Richard McNally 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 106 Orchard Manor Drv Boonsboro, MD 21713 Richard McNally/Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition ± 0 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if eny injury or once. Knoxville, MD 21758 4 ☐ Donation 5 ☐ Other (Specify) Knoxville Reformed Cem 2/7/2006 21. Signature of Funce 22. Name and Address of Facility
Pritts Funeral Home and Chapel, P.A. 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21157 Approximate Interval Between Onset and Death Ímmediate Cause (Final disease or condition resulting in death) Physician aucreatite /Medical Due to (or as a consequence of): Examiner Securations lift any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires thet the daath certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 21X No 3 ☐ Probably 4 ☐ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 X Yes 2 \( \text{N} \) No 24a. Was an page 2 s hes autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? director Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 No ၉ 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: After 1 Natural 2 Accident 5 Pending aftar death. 1 Yes 2 No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) n 24 hours aftar d 4 🗌 Homicide Medical 2 in Cartifier t 🗀 Certifying Physician: To the best of my knowledge, death considered at the time, date and place, and due to the cause(s) and manner as stated 203Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 4, 2006 tallan ud 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 1 Dr 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB alessee Registrar

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		ŀ	For State Registrar		State of	of Maryla	•	artment o			lental Hy	giene	16	04.017	j
	*	1. 7	Decedent's Name (First, I	Aiddle, Las	t)			imouto	0, 000		2. Date of Dea	ath		3. Time of Death	h
	Physici		Alice Cather	ino N	hambar						Februa Februa	ary 6	2006	12:10 a	a <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not insti			mber)		4b. City, To	wn, or Locat	tion of Death			y of Death		
d		4 -	102 Timber F	idae	Drive	#203		Wes	tmins	ster			Carr	011	
	Funeral		5. Social Security Number	6. Se	9X □M 2□√F		s. last birthday)	If Under 1 \		nder 24 Hrs.	8. Date of Birt (Month, Da June S	h v, Year)	9. Birth	place (State or Fore	sign
	Director		232-36-7262 Usual Residence of Deceder		X		77 Yrs.				June 9	1928		W.VA	
	land w		10a. State 10b. Co			10c. C	City, Town or Lo	cation						10d. Inside City Lim	nits
	Mary 	to	MD	Carro	11		Westm	inster						1 🙀 Yes 2 🗌	No
	r 28a	Funeral Director	10e. Street and Number					10f. Zip Co	de			10g. Citizen of	What Cou	ntry?	
	th wit	a	102 Timber R	idae	Drive	#203		21	157			USA			
	ems er	ner	11. Marital Status		12. Was Dec	edent Ever in	U.S. 13.	Was Deceden f Yes, specify	of Hispanio Cuban, Me	c Origin? (Spexican, Puerto	ecify Yes or No- Rican, etc.)	- 14. Ra	ce - Ameri	can Indian,	
36	within 72 hours after death with the Maryland ene. than "naturel", or items 23e or 28e-f ehow he Modes Executor coat be notified at	by Fu	1 Never Married 2		1 ☐ Yes If Yes, Gi	ve		1 ☐ Yes 2 🔀	No Spe	ecify:		Speci		White	
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212	filed within Hygiene. Ither than	mo luo	Elementary/Secondary (0-	12)	College (	1-4or 5+)		Homen	aker			Own	Home		
b	0 = 0 \$	Bec	17. Father's Name (First, Mic	idle, Last)					18. M	fother's Name	(First, Middle,	Maiden Sumai	пө)		
/lai		10 E	Albert Aman							Grace	Mayberr	Y			
Maryland	2 6 6 5		19a. Informant's Name/Rela				19b. Mailir	ng Address (S	treet and Nu	um <i>ber or R</i> ura	i Route Numbe	or, City or Town	, State, Zij	o Code)	
	B # 2 T		Dorothy Wort	hem/d	aughte			Tracey		7	Manches	•		102	
altimore,	ges 1 au if of Hea if item or othe		20a. Method of Disposition 1	tion 3 🗆	Removal from		Place of Dispo cemetery, crei	natory or othe	or r place)		Date	20c. Location	- City or T	own, State	
ţ	permit. Pages 1 Department of the important: If its any injury or ot once.		4 Donation 5 Oth			La	ke Viev	Memor	ial P	k 2/9	/2006	Sykesvi	lle,	MD:	
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			shock, or heart failure. Immediate Cause (Final	List only	one cause on	each line.			, ,	/	7 7			Interval Between Onset and Death	.0
a r	Physician /Medical		disease or condition resulting in death)	-	a. Due to	(or as a conse	1 Cal	l CAST	vern	A H	トラ	ung		13600m	H.
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Вох	requires that the death certifi een signed by the attending I hould be detached for use as	Physician/Me	23b. Was decedent pregnar in the past 12 months?	t		pirth 2 ☐ Fe nant at time of	tal death 3	Ectopic pregr					ate of deliv onth	ery Day Year	
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00	w requires been s	Completed			1		,				24a. Was	an 24b.	Were auto	opsy findings availa	ble
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ta	(A) TT	0	25. Was case referred to me	dical					26. P	Place of Death	1 Yes	2ZNo	1 🗆 Yes	2   NO	
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Division of			27. Manner of Death  1 Destural 5 P	ending	28a. Date (Mon	of Injury eth, Day Year)	28b. Time o	28c.	Injury at Work?		28d. Describe h	now injury occu	rred		
Sio	Attending ir death. ector: After by the fune	Certification:	2 Accident in	vestigation ould not be				М	1 ☐ Yes 2	2 🗆 No					
Ξ̈́	after d Direct Jin by	ŧ		termined	286. Place	of Injury - At ing, etc. (Spec	home, farm, str cify)	eet, factory, of	fice		28f. Location (S City or Tow		ber or Rur	al Route Number,	
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	Hos 24 hc Fun stely	edical	29a. Certifier 12 Cer (Check only 2 Med	lical Exam	iner: On the b	asis of examir ner stated.	nation and/or in	vestigation, in	ne time, date my opinion,	death occurr	and due to the ded at the time, d	cause(s) and m date and place,	anner as s	stated. o the cause(s)	
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			1chn	Van	On El	main		0	air	7 5		210	117	200	
(	Jew .		30. Name and address of pe	rson who	completed cau	se of death/(le	em 23a) (Type.	Print)	110	9		-/ 0	116		
	Ψ		410	Cr	nol	Cala	· Da	LUN	New	24WV	notion	000	211	57	
	Sta Registr		31. Date filed (Month, Day,	1994	2006 <sup>32, F</sup>	Registrar's Sign	nature	Sperke	,						

			1 _ State	State of Maryland			f Health ar	nd Mer		iene .g. No. 00	6 04018
50 Y		Sec.	Registrar  1. Decedent's Name (First, Middle, Last)						Date of Deat	h	3. Time of Death
130 m	Physicia	_	Julius Caes	ar Minga	relli				Month anuary		<sup>Year</sup> 06 12:30 a <sup>M</sup>
) <u>@</u>	/Medic Examin	_	4a. Facility Name (If not institution, give st	reet and number)			n, or Location of			4c. County of	Death
*			14523 Cutstone Wa				er Spri				gomery
	Funeral		5. Social Security Number 6. Sex	14 00 5		If Under 1 Y Months Da	ear If Under 24 ays Hours	4 Hrs. 8. Min.	Date of Birth (Month, Day, ug • 9 ,	Year)	9. Birthplace (State or Foreign Country) Italy
12 18	Director		Usual Residence of Decedent	83	113.			A	ug. 9,	1722	reary
	tand ow	1	10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City Limits
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	h the	Director	10e. Street and Number			10f. Zip Co	de		1	0g. Citizen of Wh	nat Country?
	th wit	aiD	2176 Rolling Hills	Court		34606	)			USA	
	r dea	Funeral	11. Wantai Status	<ol><li>Was Decedent Ever in U.S Armed Forces?</li></ol>	. 13.	Was Decedent If Yes, specify	of Hispanic Origi Cuban, Mexican,	in? (Specify Puerto Ric	Yes or No- an, etc.)		- American Indian, , White, etc.
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	ty⊡yYes 2 ∏ No liYes, Give Year or Dates: WW∐ ∐		1 ☐ Yes 2 ☐	No Specify:			Specify:	White
5-0036	within 72 hours after death with the Maryland ene. Than "natural", or Items 23e or 28e-f show the Madical Examiner and be notified at		15. Decedent's Educ		16a. Dece	dent's Usual O	ecupation			16b. Kind of Busi	iness/Industry
215	nin 72 n "na Nedic	Completed	(Specify only highest grade Elementary/Secondary (0-12)		(Give life.	kind of work d DO NOT use n	one during most o atired)	of working			
212	d with	E	12	College (1-401 3+)	Fi	reman				City Go	overnment
פ	e file al Hy i othe	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame,	)
aryland	Ment Ment arkec	2	Felice Mingarelli					ucia			7.0.4
Jar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Hygiene. I morrent: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ira Medical Examinar is not be notified at any once.	4	19a. Informant's Name/Relationship (Type Virginia L. Mingar			•				; City or Town, S nring Hi	ill, FL 34606
e,	1 and Jealth Sm 27 ther t		20a. Method of Disposition	20b. Pla	ace of Dispo	osition (Name	of .	Date			City or Town, State
Baltimore,	nt of n		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		matory`or othe		ebrua 200	-	Tohnson	City, New York
를	artme		4 □ Donation 5 ☑ Other (Specify)  21. Signatury of Luneral Service License		2:	y Cemet 2. Name and A	ddress of Facility	1	_		
Ba	Depar Impor any in		1 mhew	LCole	F   5	rancis 00 Univ	J. Coll ersity	ins F Blvd,	uneral W, Si	Home In lver Spi	nc ring, MD 20901
* 2		0	23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	ations that caused the death.							Approximate Interval Between
133	Physician		Immediate Cause (Final disease or condition	Glioblastoma							Onset and Death  1 Month
8	/Medical		resulting in death)	Due to (or as a consequ				-			
	Examiner		Sequentially list conditions, b								
	ed isit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Dus to (or as a correqu	anca oty.						
	be executed sicien and burial-transit	Examiner	that initiated events c resulting in death) Last	Due to (or as a consequ	ence of):						
8760,	death certificate be executed e attending physicien and of for use as the burial-transit	dical E	d	1						_	
9	ifficate t g physi as the t	edic									
Вох	eath certific attending pl	N/I	23b. Was decedent pregnant	3c. If yes, outcome of pregnar 1□Live birth 2□Fetal		Ectopic pregr	nancv			23d. Date Mont	of delivery hth Day Year
	ed fo	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown		Other (speci	fy)			1410111	iii Day rour
P.O.	law requires that the de as been signed by the a 2 should be detached f	Physician/Me	9 ☐ Unknown  Part II. Other significant conditions con	stributing to death but not recu	Iting in the	inderhijng caus	e awan in Part I		23e Did to	bacco use contril	bute to the cause of death?
	w requires that been signed to should be det	b	Pneumonia	thousing to death but not resu	iling in the t	andertying caus	o giveri ir s air i.				3 ☐ Probably 4 ☐Unknown
Ö	requ been shouk	Completed							24a. Was a	24h W	Vere autopsy findings available
Rec	о <u>го</u>	id III							autons	sy pr med? de	rior to completion of cause of eath?
a		ပို	25. Was case referred to medical				26 Place	of Death //	1 ☐ Yes Check only or		Yes 2 No
Ξ	Physician: rthis certific ral director,	0 8	examiner?	lospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatie	nt 3 DOA					or (Specify) Daughter's
100	g Physier this heral di	n: T	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o	of 28c.	Injury at Work?	28	d. Describe h	ow injury occurre	Residence
joi	Attending r death. sctor: After by the fune	atic	1 2 Natural 5 Pending investigation			М	1 ☐ Yes 2 ☐ N				
Division of Vital Records,	or Attendentier de Directe in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, si	treet, factory, o	ffice	28	f. Location (S City or Tow	treet and Numbe m, State)	er or Rural Route Number,
Ω	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After thi completely filled in by the funeral		On Continue of the Continue of	sision. To the best of my know	uladas dos	th accurred at	the time date and	d place, an	d due to the	cauco(c) and man	nnar ac etated
	To the Hospital within 24 hours a To the Funerel C completely filled	edical	29a. Certifier 1 Certifying Physics (Check only one) 2 Medical Examination	sicien: To the best of my knowner: On the basis of examinat and manner stated.	ion and/or i	nvestigation, in	my opinion, deat	th occurred	at the time, o	date and place, a	and due to the cause(s)
	o the	Me	29b. Signature and title of certifier			29c. L	icense number		-	29d. Date signed	i (Month, Day, Year)
	->-0		1 VILLO				D35045	;		Jani	uary 26, 2006
			30. Name and address of person who co	ompleted cause of death (Item	23a) (Type	, Print)			1	Juin	
13	5+1		Philip Henjum, M.D				ive, #20	0, 01	ney, M	1D 20832	
G.	St Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 7 20	32. Pegistrar's Signal	ture	parti					

		•	For State Registrar	State of Ma	aryland /	•	ment of H icate of L		nd Menta	ا ال Hygier جووبا	711116	04019
			1. Decedent's Name (First, Middle, Las	st)						e of Death	Day Year	3. Time of Death
Н	Physici /Medic		Vera C. Mc	Kenzie						nuary	27, 2006	12:00A M
	Examin		4a. Facility Name (If not institution, give	e street and number)		45	. City, Town, or	Location of	Death		4c. County of Dea	th
			Northampton Manor	Health Ca	re Cer	nter	Frederi	ick			Freder	ick
	Funeral		Social Security Number     6. S		(In yrs. last	M	Under 1 Year onths Days	If Under 2 Hours		e of Birth onth, Day, Yea	9. Bir	thplace (State or Foreign
	Director		210 32 0000	I□M 2\ XF	88	Yrs.			Ma	onth, Day, Yea	1917 Ma	ryland
	pu .	1	Usual Residence of Decedent  10a. State 10b. County		10c City To	own or Location						10d. Inside City Limits
	aryla shor	5	Maryland Montgom	norw.	_	scus	011					1 ☐ Yes 3√☐ No
	he M	ecto	10e. Street and Number	ELY	Danie		04 71- 0-4-			10-	Citizen of What C	
	with t	吉	9813 Bethesda Ch	wah Daad			Of. Zip Code	7.0		10g.		
	within 72 hours after death with the Maryland ene. than "natural", or Itams 23e or 28e-1 show in Medical Exertines I be motified at	Funeral Director		12. Was Decedent E	Tues in III C	12 14/00	2087		ing (Canadh) Va	a ar Na	U.S.	
	ltam	'n	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces?		If Ye	Decedent of Hi s, specify Cuba	n, Mexican,	Puerto Rican,	etc.)	Black, Whi	
36	rs att	by F	3 ₩ Widowed 4 Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1 🗆	Yes 2 No	Specify:			Specify: W	nite
21215-0036	tura tura	ed	15. Decedent's Ed		16	Sa. Decedent	's Usual Occupa	ation		16b.	. Kind of Business	
15	in 72 n " n	Completed	(Specify only highest gra	ade completed)		(Give kind lite. DO l	i of work done d NOT use retired,	during most )	of working			Í
72	with iene.	E O	Elementary/Secondary (0-12)	College (1-4or 5-	+)	Homema	ker				Own Home	2
D	filled Hygi other ant, I	Bec	17. Father's Name (First, Middle, Last)	)		HOMOMO		18. Mother	's Name (First,	Middle, Maid		
an	lid be ental ked c	To B	Jason Wilb	urn				۸۳	nie Di	irct		
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic evant, ILE M.	,-	19a. Informant's Name/Relationship (		1	9b. Mailing A	ddress (Street a				y or Town, State,	Zip Code)
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. item 27 is marked other than "natural", or Itams 23a or 28a-1 show other traumatic evant, it a Medical Exact has it must be multipled at		Rodney McKenzie -	Son		9203	as Hous	se Pik	e. Fre	ederick	k, Maryla	and 21701
altimore,	as 1 and 2 of Health litam 27 l		20a. Method of Disposition		20b. Place	of Dispositio		1	Date		Location - City or	
E O	8°= 5		1 ☑ Burial 2 ☐ Cremation 3 ☐  14 ☐ Denation 5 ☐ Other (Specify						ens 2/0	1/06	Frederic	k, Maryland
≣	nit. Pagartment ortant: injury e.		21. Signature of Funeral Service Aser	7 200		22. Na	me and Addres	s of Facility				
ä	Dermi Depai Impor any ir		Forest L.	Willian	ns	Mole	sworth-	Willi	ams P.A	., Fun	neral Hom	ie I 20872
			23a. Part1. Enter the disease, or com	plications that caused	the death. D						Maryland	Approximate
u	a Comme		shock, or heart failure. List only Immediate Cause (Final									Interval Between Onset and Death
1	Prrysician /Medical		disease or condition resulting in death)	a Metast  Due to (or as a			Cancer					Months
В	Examiner			Severe								Years
		ь	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a								
	uted	듵	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
Ć,	death certiticate be executed e attending physician and of for use as the burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a	a consequenc	ce of):						
8760,	sicia bur	g		d								
68	iticati g phy as the	Physician/Medical		-								
Вох	leath certitic attending p	Z.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d. Date of de	livery
ă	death s atte	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 4⊡Pregnant at			opic pregnancy her (s <i>pecify)</i>				Month	Day Year
O.	the d by the	S	9 ☐ Unknown	9∐ Unknown								
	a 5 6	=	9 🗆 Unknown								<del></del>	
<u>α</u>	that ed b deta		Part II. Other significant conditions of	ontributing to death bu	ut not resultin	g in the under	tying cause give	an in Part I.	23	e. Did tobacc	o use contribute t	o the cause of death?
S, D	es ign pe	by		contributing to death bu	ut not resultin	g in the under	tying cause give	an in Part I.	23	le. Did tobacc		o the cause of death?
S, D	v requires been sign	by		contributing to death bu	ut not resultin	g in the under	lying cause give	an in Part I.	_	X Yes a. Was an	2 No 3 □ P	robably 4 Unknown
S, D	e faw requires has been sign je 2 should be	by		contributing to death bu	ut not resultin	g in the under	tying cause give	en in Part I.	24	Yas an autopsy performed	2 No 3 P	robably 4 Unknown utopsy findings available completion of cause of
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	Physici /Medio Examin	ai	Decedent's Name (First, Middle, Last)     ABDVL     4a. Facility Name (If not institution, give streen)	MAJEEL et and number)	)	4h City I	Town or	Location o	,	2. Date of Dea Month JAN	26	Year 2000 ounty of Deal		
	Funeral	ier	5801 MEADON 5. Social Security Number 6. Sex.	JRIVE  7. Age (In yrs. last		F/Z	EDE	If Under 2	K	8. Date of Birt (Month, Day NOV 5,	FR	EDER		oreign
	Director		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	Yrs.					NOVS,	1938	3	10d. Inside City I	
	with the Mar sa or 28a-f sh the notified	Director	MD, FREDERIC 10e. Street and Number 5801 MEADOW	, ,-0	DER	10f. Zip	Code	)-)			-	on of What Co	1 ☐ Yes 2	ØN∘
980	72 hours after death with the Maryland natural', or Items 23a or 28a-f show lical Exarchest aust be notified at	by Funeral Director	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces?  1		-	ent of His fy Cubar		gin? (Spec , Puerto F	cify Yes or No- lican, etc.)	- 14	Race - Ame Black, Whit		
2121	be filed within 72 hours ital Hygiene. id other than "natural", event, tre Medical Exe	Completed			(Give life.	dent's Usual kind of work DO NOT use	done de retired)	uring most	of workin	g	SEL	of Business, F Loye,	MEDICAL	_
Maryland		To Be	17. Father's Name (First, Middle, Last)  5, M, IBRAHIM  19a. Informant's Name/Relationship (Type,	,	Ob. 44-10			HAFI	TZA	(First, Middle,	SHI			
_	1 and 2 Health a sm 27 ls		RATE MATELD  20a. Method of Disposition	(50V) 3	281		8TH .	SE 5	CATTL	Route Number	HIN 6		8177	
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	Physician /Medical Examiner		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one commendate Cause (Final disease or condition resulting in death)  Sequentially list conditions	ons that ceused the death. D	o not ent	er the mode	of dying	, such as o	cardiac or		rest,	mo e	Approximate Interval Betwee Onset and Dea	en ath nths
8760,	death certificate be executed e attending physician and of for use as the buriat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Due to (or as a consequence										
		Physician/Medical		If yes, outcome of pregnancy 1   Live birth   2   Fetal dea 4   Pregnant at time of death 9   Unknown		Ectopic pre					23	d. Date of del Month	ivery Day Yea	ar .
ords, P	law requires that the as been signed by th 2 should be detache	by	Part II. Other significant conditions contrib	uting to death but not resulting	in the u	nderlying ca	use give	n in Part I.		23e. Did to	_		the cause of deat	
Œ.	The ate his page	Completed	V								med? 2 No	24b. Were au prior to death? 1 ☐ Yes	topsy findings ava completion of caus 2 1 No	ulable se of
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	To the Hospital or Attention within 24 hours after deatl To the Funerel Director: completely filled in by the	Medical	(Check only one)  2 Medical Exeminer:  29b. Signature and title of certifier	On the basis of examination and manner stated.	and/or in	estigation, i	in my opi	nion, death	n occurred	d at the time, o	date and pl	ace, and due	to the cause(s)	
,	6		30. Name and address of person who compl	eted cause of death (Item 23a  46B Thomas  32. Re strar's Signature	) (Type,	Print)	ر د	1/0	1.5	5 S	Jernuc	ary 26	,2006	
	Sta Registr	100	Kanan Hudhud, mo 31. Date filed (Month, Day, Year) JAN 3 0 200	32. Restrar's Signature	johu.	son on	nva.	+1e	aeri	ck, m	リメ	170,1		

ORIGINAL

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							Cei	tificate	of L	)eatn				000	04061
	Physicia	212	1. Decedent's Name	(First, Middle, Las	t)						2	. Date of De Month	Day		3. Time of Death
	/Medic		Velma		Nevara	a			.11eı			lanuar		, 2006	7:20 pm <sup>M</sup>
}	Examin	er	4a. Facility Name (If			ber)		4b. City, T			of Death			County of Dea	
			Reeders M					Boon		r O If Under	04 110 1 0			shingt	
	Funeral		5. Social Security Nu 259-34-239		9X □M 2527 F	. Age (In yrs	last birthday) Yrs.		Days	Hours	Min.	. Date of Bir (Month, Da	y, Year)	9. Bir	thplace (State or Foreign
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	and and			10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
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an	of the b	To Be	James Lew	is Donal	son					A11	ie Go	lden E	Barbi	ee	
3	S D E E	-	19a. Informant's Nar	me/Relationship (7	ype, Print)		19b. Maili	ng Address	(Street a	nd Numbe	er or Rural I	Route Numb	er, City o	r Town, State,	Zip Code)
Baltimore, Maryland 21215-0036	12 7 1/2 tra		Harry J.	Miller/S	on		11919	Sun	Vall	ley D	r., H	agerst	own :	, MD 2	1742
Je,	of Healt item 2 other	4	20a. Method of Dispo			1 0	Place of Dispo	sition (Nam	e of her place	9)	Dat	te	20c. Lo	cation - City or	Town, State
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alti	permit. Departri Importa any inju		21. Signature of Fun	eral Service Licen	see	'	22	2. Name and	Addres	s of Facilit	ty Res	t Have	en Fu	ıneral	Chapel
m	g g E E 8		> 5.M	nk Si	no		10	501 Pe	nnsy	ylvan	iia Av	e., Ha	gers	stown, l	MD 21742
			23a. Part 1. Enter the shock, or heart	e disease, or comp failure. List only	olio tons that car	used the deat ch line.	h. Do not en	ter the mode	of dying	such as	cardiac or	respiratory a	rrest.		Approximate Interval Between
8	Physician		Immediate Cause (F	Final	·	Nehro	VASCU	Jav	RC	wd	ent	_			Onset and Death
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Вох	atter for u	clar	23b. Was decedent in the past 12 r	nonths?	1□Live bir	th 2 ☐ Feta nt at time of d	l death 3	□Ectopic pre □ Other <i>(spe</i>						Month	Day Year
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<u>α</u>	s that	by Pł	Part II. Other signific	cant conditions c	ontributing to dea	ath but not res	ulting in the u	nderlying ca	use give	en in Part I	1.	23e. Did	tobacco (	ise contribute t	o the cause of death?
Records,	quires n sign ald be	g D	Dick	hatensii	elli hus							1 🗆	Yes 2	□No 3□P	robably 4 Unknown
00	law requir as been si 2 should	olete	Hu	Matensia	$\sim$							24a. Was		24b. Were a	utopsy findings available
Re	The la ate ha: page 2	Completed	- //									auto perfe 1 ☐ Yes	ormed2 2 No	death?	completion of cause of
Vital		e e	25. Was case referre	ed to medical						26. Place	e of Death (	Check only			
>	Physician: this certific ral director,	OB	examiner?		Hospital: 1 🗆 In	patient 2	ER/Outpatie	nt 3 🗆 DO	A Othe	er: 4 Nu	ursing Home	e 5 🗆 Resi	idence	6 □Other (Spe	ecify)
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jo	Attending I ir death. ector: After by the funer	atlo	1 Natural 2 ☐ Accident	5 Pending investigation		, our rour,	ii ijai y	М		Yes 2	No No				
Division	or Attend after death Director: A	tifle	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	280. Place	of Injury - At h	ome, farm, st	reet, factory,	, office		28	If. Location ( City or To			ural Route Number,
Ö	tal or	Certification:													
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only	Certifying Ph 2 Medical Exan	ysician: To the t	oest of my kno	owledge, deal	h occurred a	at the tim	ne, date ar pinion, dea	nd place, an	nd due to the	cause(s	and manner a	s stated. e to the cause(s)
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Comments    Comments				State of Maryland / Department of Health  1- For State Registrar  Certificate of Death		lygiene Reg. No: 006	04022
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29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  (Check only of the course of the cause o		Diversion of the property of t	erti	4 ☐ Homicide determined building, etc. (Specify)	City or 7	Town, State)	
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1 1 / No 2006		To t Vithi To tl	Σ				
30. Nation of address of perion who completed cause of death (Item 23a) (Type, Print)  State Registrar  30. Nation of address of perion who completed cause of death (Item 23a) (Type, Print)  State Registrar  EFB 0 1 2006						Jon. 30,	2006
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				ST. Date med (Month, Day, Fear) 32. Highstrars signature	·		

			1 - For State Registrar		Marylar		artment of I		nd Mei	ntal Hygi	g. No.	06	0402	23
П	Dhycini	-	Decedent's Name (First, Mid	dle, Last)					2.	Date of Death Month	Day	Year	3. Time of	
	Physici /Medio		Hilda	Α			Osborne			ANUARY	20	2006	5:05	PM
	Examir	ner	4a. Facility Name (If not instituti		,		4b. City, Town,		Death		4c. Co	ounty of Death		
			Calvert Manor  5. Social Security Number			last birthday)	Risin If Under 1 Year	g Sun	Hrs o	Data of Birth		Cecil	l (04-4	· C- · · · ·
	Funeral Director		221-07-4959 Usual Residence of Decedent	1 M 2 M F	92	Yrs.	Months Days		Min.	Date of Birth (Month, Day, Uly 22	Year) 191		lace (State of try) OWINGO	
	yland		10a. State 10b. Coun	ty	10c. Ci	ty, Town or Lo	ocation					1	0d. Inside Cit	y Limits
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	or 28	ire	10e. Street and Number				10f. Zip Code			10	g. Citize	n of What Coun	itry?	
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	er de	Funeral Director	11. Marital Status	12. Was Decede Armed Force	s?	l.S. 13.	Was Decedent of If Yes, specify Cub	Hispanic Origin ban, Mexican, P	? (Specifi Puerto Ric	y Yes or No- an, etc.)	14.	<ul> <li>Race - Americ Black, White,</li> </ul>		
36	rs aft	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes, Give	•		1 ☐ Yes 2 💢 No	Specify:			S	pecify: Wh	ite	
8	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "natural", or items 23a or 28a-f ehow event, it a Medical Exaction trinst terrified at	ed		ent's Education	<u> </u>	16a. Dece	dent's Usual Occu	pation		1	6b. Kind	of Business/Inc	dustry	
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Maryland 21215-0036	2 2 2 2 3		19a. Informant's Name/Relation			1	ng Address (Stree							
	1 and Health em 27		M. Joanne Lan  20a. Method of Disposition	DOTT	20h F		Lancast		Date	ckessi		E 1970 tion - City or To		
Baltimore,			1 ☐ Burial 2 风吹remation		ra		sition (Name of natory or other pla							
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			23a. Part. Enter the disease,	or complications that caus	sed the deat							DL 15	Approximate	
	Enysician		Immediate Cause (Final	st only one cause on each		- Mili	TI-INFAR	RCT					Onset and D	reen Teath
	/Medical		disease or condition resulting in death)	a	as a conseq		7,411.1							
	Examiner		Sequentially list conditions	b										
	D #	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury		as a conseq	juence of):								
	ecute and trans	Examiner	that initiated events resulting in death) Last	C. Due to (or	as a conseq	uanga af):						-		
8760,	icate be executed physicien and s the burial-transit	ical E		500 10 (0)	43 A CO11364	juerice dr).								
687	death certificate be executed e attending physicien and id for use as the burial-transit	edic		d										
Вох	eath certific attending p	N N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom							230	d. Date of delive	ry	
-	death e atte	icia	in the past 12 months? 1 □ Yes 2 No	1☐Live birth 4☐Pregnant	at time of d		]Ectopic pregnand ] Other <i>(specify)</i> _	У				Month	Day Y	'ear
P.0	that the de led by the a detached t	Physician/M	9 🗆 Unknown	9L Unknown									·····	
Records, I	law requires that the as been signed by the 2 should be detache	þ	Part II. Other significant condi	ions contributing to death	n but not res	ulting in the u	nderlying cause gr	ven in Part I.		23e. Did toba		contribute to the	e cause of de ably 4 ⊡U	
၀	aw re	Completed							ĺ	24a. Was an	2	24b. Were autop		
Ä	9 2 9	E O							_	autopsy perform 1 Yes 2	ed? X No	death?	npletion of ca 2□ No	.use 01
Vital	ysician: Th is certificate director, pag	Be (	25. Was case referred to medic examiner?					26. Place of	Death (C	heck only one	·			
of V	hysic his ce il dire	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa		ER/Outpatien	1 3 DOA		ng Home	5 🗌 Residen	ce 6	Other (Specify	')	
n o	iding Phy th. : After this funeral d	iuo!	27. Manner of Death  1 Natural 5 Pend		njury Da <i>y Year)</i>	28b. Time of Injury	Wo		1	I. Describe how	injury o	ccurred		
Sio	Attending Physician: r death. sctor: After this certifici by the funeral director.	icat	3 ☐ Suicide 6 ☐ Could		Inium. At h			]Yes 2□No	-	Logation /Ctm	at and A	lumber or Our	I Courte Musel	
Division	or A efter Direc	ertification;	4  Homicide deter	mined 286. Place of building,	etc. (Specif	y)	eet, factory, office		201.	City or Town,		lumber or Rura	r Aoule Numi	ier,
_	To the Hospital or Attent within 24 hours efter death To the Funerel Director: completely filled in by the	edical C	29a. Certifier Certify (Check only one)	ing Physicien: To the best	of examina	owledge, death	occurred at the ti	ime, date and plopinion, death o	lace, and	due to the cau at the time, dat	ise(s) an o and pla	d manner as st ace, and due to	ated. the cause(s)	
	o the	Mec	29b. Signature and title of cent	and manner	Jiaidu.		29c. Licen	se number		296	d. Date s	igned (Month, I	Day, Year)	
)	F ≯ F ŏ		Nahal				458							
	10		30. Name and address of perso	n who completed cause o	f_death (Iten	n 23a) (Type.	Print)	1 ' /				my 23, 2 HAM, D.		
62	1		1881 TELEGRA	PH ROAD	RISING	, SUN,	MD 21	911	,	KODNEY	Don	I.a. MAH	),	
N.	Sta Registr		JAN 3 1 2006	See 32. Regis	strar's Sign	ture	Print) 21							

			1 - For State Registrar	State of Ma	rylan		artmen rtificat			and Me	-	giene	006	0402	
	Physici	an.	1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	Day	Year	3. Time of Dea	
	/Medic		Lindsay Emerson								Janua		3, 2006		7 M
	Examir	er	4a. Facility Name (If not institution, give 10633 Oaklyn Driv					Town, or toma	Location of	t Death			County of De		
	Funeral	8.7	5. Social Security Number 6. S		(In yrs.	last birthday)		1 Year	If Under 2	24 Hrs.	8. Date of Bir			irthnlace (State or Fo	oreign
Ы	Director			<b>™</b> 2□ F	8	4 Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Nov • 5	192	21 Vi	cginia	
	p ,		Usual Residence of Decedent  10a. State 10b. County		100 Cib	y, Town or Lo	oatio=							10d. Inside City L	imite
	sho	'n				tomac	Cation							1 Tyes 2	
	the N	ect	Maryland Montgome	ery	- 10	Lomac	10f. Zip	Code				10a, Citi;	zen of What (	Country?	
	3a or	i Di	10633 Oaklyn Dri	ve				854					ed Sta	-	
	death	Funeral Director	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.		Was Dece	dent of Hi	spanic Orig n, Mexican	gin? (Spec	city Yes or No	-	14. Race - An Black, Wh	nerican Indian,	
9	or Ite	/ Fu	1 ☐ Never Married 2 🛣 Married	1 ☐ Yes 2 ☐ Mo	)		1 ☐ Yes		Specify:	, 1 40110 1	riodii, oto.,				
Ö	hours ural',	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		102 Days	d 1							an America	ın
5	in 72	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		16a. Dece (Give life.	kind of wo DO NOT u	rk done a	lurina most	of workin	g	IBD. KII	nd of Busines	s/industry	
212	d with giene.	omp	Elementary/Secondary (0-12)	Coifege (1-4or 5+	·)	Prop	rieto	r Se	rvice	Sta	tion	Gas	soline	Station	
פַ	al Hyg othe	BeC	17. Father's Name (First, Middle, Last)								(First, Middle	Maiden	Sumame)		
Jai	Mente	ToE	Preston Cecil Pa	trick					Mat	tie	Hubbar	1			
lan.	2 sho		19a. Informant's Name/Relationship (				151				Route Numb			Zip Code)	
a)	1 and 1ealth em 27 ther ti			aughter)	20h B	_	The second second				ville,		20783	or Town, State	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injuxyor other traumatic event, it a Marical Encillet man be retilized at once.		20a. Method of Disposition 1 ☐ Burial 2 【○ Cremation 3 ☐			face of Dispo emetery, crer							-		
Ħ	ntant niury		4 □Donation 5 □Other (Specify  21. Signature of Funeral Service Licen		Cne	sapeak				1/30	/2006	ReTt	sville	<b>,</b> MD	
Ba	Depi Impo		Instré Ja	- 1100 - 1 100 - 1							ire Fu				)12
			23a. Part1. Enter the disease, or com	plications that caused t	he deatl								180011,	Approximate Interval Between	
	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	Acute 1		ardia1	Inf	rcti	on					Onset and Dea	th
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8760,	ate be executed hysicien and the burial-transit	icai E		Diabete			s								
မှ	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	PG		. d											
Вох	leath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o			Ectopic p	remanev				2	3d. Date of d	,	
B	e deal	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at t			Other (s						Month	Day Yea	
о. О.	that the de ned by the s detached f	Phy	9 Unknown			. late - t- ate			. is Book!		220 Did	abassa u	aa aantsihuta	to the source of doct	h2
Js,	ires the signeral bed	by	Part ff. Other significant conditions of	oninbuting to death but	not resi	uiting in the u	ngeriying (	ause give	en in Part I.		1			to the cause of deat Probably 4 Unk	
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a	ificate or, pa	e Co	25. Was case referred to medical						26 Diago	of Dooth	1 Yes		1 🗆 Y	es 2½ No	
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0	g Phy ter thi		27. Manner of Death	28a. Date of Injury (Month, Day		28b. Time of		28c. Injury Work			8d. Describe				
Sio	Attending in death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident investigation	1	, ,	,	М		Yes 2□N	No					
<u>×</u>	or Att	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injurbuilding, etc.	y - At ho (Specify	ome, farm, str	eet, factor	y, office		2	8f. Location ( City or To			Rural Route Number	
	pital o														
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	To the Hospital or Attending Physicien: The lav within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Mec	29b. Signature and title of certifier	A .	· · ·		29	c. License	number			29d. Dat	e signed (Mo	nth, Day, Year)	
	$\hat{\nu}$		Vinu Gan	<b>Y</b>			I	411	62			Janua	ary 24	2006	
•			30. Name and address of person who	completed cause of de	ath (Item	23a) (Type,			<u> </u>					,	
			Vinu Ganti, M.D.	19529 Doct					town,	MD	20874				
ll s	Sta Registr		31. Date filed (Month, Day, Year)	2006	's Signa	b. A	mell	9							
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			1 - State State Registrar	e of Maryland / Depa	artment of H rtificate of L			2000	04025
0	9.0%		Decedent's Name (First, Middle, Last)				2. Date of Death	. No.	3. Time of Death
3	Physici		Virginia Allen	1	Polin	-	Month January 2	Day 2006	8:45 A <sup>M</sup>
1	/Medic Examin		4a. Facility Name (If not institution, give street and		4b. City, Town, or		andary a	4c. County of De	
	Examin	er	Gladys Spellman Nursin		Cheverly			Prince (	_
	Funeral		Social Security Number	7. Age (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9. E	Birthplace (State or Foreign
4	Director		221-16-7035 1□M 2X	F 78 Yrs.	Months Days	Hours Min.	(Month, Day, ) v • 8 , 19	27 Ma	Country) aryland
- A	P .		Usual Residence of Decedent						
	arylar		10a. State 10b. County	10c. City, Town or Lo					10d. Inside City Limits
	Ba-f s	cto	Delaware Sussex	Seaford					1 ☐ Yes 2X No
	or 2	Directo	10e. Street and Number		10f. Zip Code	•		. Citizen of What	
	within 72 hours after death with the Maryland iene. r then "naturel", or Itams 23a or 28a-f show It a Madical Examinet must be motified at		6749 Atlanta Circl		1997			America	
	er de Itami	Funerai	Armed		Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Ai Black, W	merican Indian, hite, etc.
9	s aft	by F	If Yes,	es 2 ∰ No , Give or Dates:	1 ☐ Yes 2🔀 No	Specify:		Specify:	White
3	hou		15. Decedent's Education		dent's Usual Occupa	ation	16	b. Kind of Busine	
ဌ	C 2 (3)	piet	(Specify only highest grade complete	(Give	kind of work done d DO NOT use retired)	luring most of working	g		,
7	filed within I Hygiene. other then "	Completed	Elementary/Secondary (0-12) Colleg	ge (1-4or 5+) Hom	nemaker			Domesti	C
ğ	filed w Hygier other ti	BeC	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma	iden Sumame)	
<u>a</u>	2 t 2 2	To B	Charles Francis	Rogers		Kitty	Allen		
Maryland 21215-0036		-	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street a	and Number or Rural	Route Number, (	City or Town, State	e, Zip Code)
	and 2 ealth a m 27 ls		Bernard A. Polin -	· Husband 674	9 Atlan	ta Circl	e Seaf	ord, DE.	19973
Baltimore,	s 1 a of Hei Itam oths		20a. Method of Disposition	20b. Place of Dispo	sition (Name of	Di Di	ate 20	c. Location - City	or Town, State
Ë	Pages nent of int: If It iry or o		1 ☐ Rurial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	Church		opa 1/2	27/06 S	eaford,	Delaware
3	permit. Page Department of Importent: If any injury or once.	1	21. Signature of Funeral Service Licensis			Funeral	Servic	e. Inc.	
ñ	in per		Lennis Fills	72	ll Lee	Hwy Fall	s Chur	ch, Virg	inia 22046
. *			23a. Part1. Enter the disease, or complications th	at caused the death. Do not ent	er the mode of dying	g, such as cardiac or	respiratory arres	t,	Approximate Interval Between
	Physician		shock, or heart failure. List only one cause of immediate Cause (Final		2	<b>&gt;-3</b>	, ,		Onset and Death
) [	/Medical			to (or as a consequence of):	6 STZ-1	nets me	いいいかい	Jid Cit	7=205
	Examiner			( (					
	The state	Jer	Sequential visit conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	to (or as a consequence of):					,
	cuted nd ransif	Examiner	that initiated events						
o^	exe en ar rial-t	Ĕ		to (or as a consequence of):					
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õ	leath certifica attending ph I for use as the	Med	IF FEMALE:						
X Q	th ce tendi	Physician/Me	23b. Was decedent pregnant 23c. If yes,	, outcome of pregnancy ve birth 2 □Fetal death 3□	Ectopic pregnancy			23d. Date of	
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r Ö	at the de 1 by the a stached	Phy	9 Unknown				1		
	w requires that the sbeen signed by th should be detache	þ	Part II. Other significant conditions contributing t	o death but not resulting in the un	nderlying cause give	12 165	+ 150		to the cause of death?
Ś	inper s	ted	Meshivalory Ta.	Luxe Jent	VEDYE	EVO MICH	1 Yes	2 No 3	Probably 4 Unknown
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ecords,	0 00	므	Thinks of and	7 C CONTECTION	asular	Distect	24a. Was an	prior	autopsy findings available to completion of cause of
l Record	The la ate has page 2	Somp	truenos (evel	7 E CANSICOL	ajulan	District	autopsy performe	d2 prior t	to completion of cause of ?
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/Medic		Walter H. Pr		•	T		Januar		
Examir	ner	4a. Facility Name (If not institution,	-		4b. City, Town, o	r Location of Death		4c. County of De	
74 S			emorial Ho	Spital e (In yrs. last birthda	) If Under 1 Year	Easton If Under 24 Hrs.	9 Date of Birth	Talb	ot inthplace (State or Foreign Country)
Funeral Director		064-24-1654	1 M M 2□F 8		Months Days	Hours Min.	(Month, Day, 5-4-19	925 Br	ooklyn, N.
P.		Usual Residence of Decedent							
arylar show	_	Md Talbo	nt-	10c. City, Town or St. Mi	chaels				10d. Inside City Limits 1 ☐ Yes 3€☐ No
with the Maryland a or 28a-f show	Director	10e. Street and Number			10f. Zip Code		1/	Og. Citizen of What (	
filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or itema 23s or 28s-f show ent, the Medical Exeminar must be notified at		24362 Widgeok	Dlago II	ni+ #1	21663	3		USA	Southly :
be filed within 72 hours after death w tal Hygiene. d other than "natural", or itema 23a event, the Medical Exeminar must	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		. Was Decedent of H		ecify Yes or No-	14. Race - An	
or Ite		1 ☐ Never Married 2 🕅 Marrie	id 1X□Yes 2□N	lo .			Rican, etc.)	Black, Wh SpecWhi	
ours a	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	Navt	1 ☐ Yes 2 💢 No	Specny:		Specify111	
72 h	Completed	15. Decedent's (Specify only highest	Education grade completed)	16a. Dec	edent's Usual Occup re kind of work done DO NOT use retired	nation during most of work	ing	16b. Kind of Busines	s/Industry
within ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)	ertisino			Owner	
Hygie Other I	ပိ	12 years 17. Father's Name (First, Middle, L	4 years	Adv	ercisin	18. Mother's Name		•	
0 = 0 5	To Be	Walter H. P.		•			sRath		
12 should be f and Mental b 7 is marked of raumatic eve	F	19a. Informant's Name/Relationsh	ip (Typa, Print)	19b. Ma	ling Address (Street	and Number or Rura	al Route Number,	City or Town, State,	Zip Code)
and 2 ealth a n 27 ls		Irene B. Pres	ston	243	62 Wida	oon Dl	Hn4+ #	1 C+ 504	-k1- wa
permit. Pages 1 and 2 should be filed within 72 hours atl Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or eny injury or other traumatic event, the Modical Examinance.		20a. Method of Disposition		20b. Place of Dis	position (Name of ematory or other place	ce)			chaels Md.
Pages nent of int: If it		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ∐Removal from State scify)	Olivet	ematory or other place Cemeter	ý 2-3-2	2006 S	t. Micha	aels, Md.
permit. Pages 1 and 2 should by Department of Health and Menta Important: If Item 27 Is marked eny injury or other traumatic evonce.		21. Signature of Funeral Service L	icensee	/	22. Name and Addre	ess of Facility	ar Euro	wal Home	NDC
88 5 8		K. Canul	1 this	120				ral Home	ePC
		23a. Part1. Enter the disease, or c shock, or heart failure. List of	complications that caused only one cause on each lin	the eath. Do not e	nter the mole of dyir	ng, such as cardiac	or respiratory arre	est.	Approximate Interval Between
Physician	8	Immediate Cause (Final disease or condition	. Acute	QI.	bleed -	Rector/			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as	a consequence of):					
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ped isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of):					
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leath certificate attending phy i for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		□Ectopic pregnancy	,		23d. Date of d	•
deati e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at		Other (specify)	· · · · · · · · · · · · · · · · · · ·		Month	Day Year
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es thi	by	Part II. Other significant condition	ns contributing to death be	ut not resulting in the	underlying cause giv	ven in Part I.			to the cause of death?
requires that een signed b hould be deta	Completed	1 cm	17134486				1 ☐ Ye	es 20€1No 3⊡I	Probably 4 Unknown
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Physical this call dir	2	1 Yes 2 No	1 Inpatie		ent 3 DOA	-4(Minuraing Ha		ence 6 Other (Sp	pecify)
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dea ctor y the	든	4 ☐ Homicide determin	building, etc	c. (Specify)			City or Town	, State)	
after dea.	0		Physician: To the best						
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	Examin		4a. Facility Name (If not institution, giv				or Location of Death		4c. County of Deat	
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	Funeral Director				79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	9 2 6 Co	thplace (State or Foreign buntry) NY
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Mor	88-f a	ector	MD Carolin	le l	Denton	10f. Zip Code		4/	ng. Citizen of What Co	1 TYes 2 No
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	natura lical E	ted	15. Decedent's E (Specify only highest gr	ducation	16a. Dece	dent's Usual Occup	oation during most of work	kina	16b. Kind of Business	•
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ָר ער בו	ages I all ant of Hee at: If item y or other		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Speci	Removal from State	b. Place of Dispo cemetery, cred Capato	osition (Name of matory or other pla Cremat	ge) Lory 2/5	Date 2 / 0 6	20c. Location - City or Over, DE	
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10	ertifica sctor, p	Bec	25. Was case referred to medical examiner?			10ml		th Check only on		
5 2	this can dire	မ	1 ☐ Yes 2 No  27. Manner of Death	Hospitaf: 1 2 Inpatient :	2 ER/Outpatie	111 3 DOA			once 6 Other (Spe	ecify)
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			30. Name and address of person who		(ftem 23a) (Type		21601			
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Elizabeth R. Clifford (Daughter) 13662 Spinning Wheel Drive, Germantown, MD 203.  202. Method of Discosition (Super Species) (Name of Spec	s ma		19a. Informant's Name/Relationship (T)	rpe, Print)	19b. Mail	ing Address (Street and Number or Rur	al Route Numbe	r, City or Town, State, Zip Code)
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23. Plate of delivery many large and proposed and the second program of the second progr	mit.		21. Signature of Funeral Service Licens	7	2	$^{2}$ 2. Name and Address of Facility $\mathrm{D}\epsilon$	Vol Fun	
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Immediate Cause (Final dease)   Condition   Cealing in death)   Due to (or as a consequence of):   Due to (or as a cons			23a. Part 1. Enter he disease, or comp	ications that caused the de	eath. Do not en	nter the mode of dying, such as cardiac	or respiratory are	rest, Approximate
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30. Name and address of person who completed control of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue  TERFY L. COPECS MR Handratown MD 217/2	the the mplet	Jed		and manner stated.		20c License number		29d Date signed (Month Day Vear)
30. Name and address of person who completed c e of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue	To To	~	29b. Signature and title of certifier	-	-			1/29/110
JERRY L. COPRECES IND Hagaratory MD 217/2	20		/ try/ h	N.M.	10.	100041131		1/2404
JEPTY L. COTTE CO MIL Hagaratour MD 217/2				process of the second second	tem 23a) (Type	<sup>0, Print)</sup> 1500 Pennsylva	nia Aver	nue
State 31. Date filed (Month, Day, Year) 32. Degistrar's Signature			2011	100		Hacarataun MD		
Registrar IAN 2 0 2006				AND THE RESERVE OF THE PERSON NAMED IN COLUMN TO SERVE OF	gnature	onell		

Warren Rosin 06-00810 d1

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		Amend Unpend i	State of	Maryland / I	Dépa	irtment of H	lealth a	and M	ental Hy	gien	e	01000		
		1 - State Ragistrar				tificate of				Reg. N	211116	04030		
ysici	an	Decedent's Name (First, Midd	le, Last)						<ol><li>Date of D Month</li></ol>	D	ay Year	3. Time of Death		
ledio	cai	Warren A. I  4a. Facility Name (If not institutio	Rosin	herl		4b. City, Town, or	Longtion	of Dooth	Febru		1, 2006 c. County of Dea	7:05 P <sup>M</sup>		
amin	ier	13210 Meander				Germant		or Death			iontgome:			
eral		5. Social Security Number	6. Sex 7	'. Age (In yrs. last bii	thday)	If Under 1 Year	If Under	24 Hrs.	8. Date of B			L y thplace (State or Foreign oun <i>try)</i>		
ctor		216-60-0568	1⊠M 2□F	53	Yrs.	Months Days	Hours	Min.	June 1	10,1952 Washington, D				
-		Usual Residence of Decedent  10a. State 10b. County	,	10c. City, Tow	n or Lo	cation						10d. Inside City Limits		
9	to	Maryland Mont	tgomery	German	t our	n						1 ☐ Yes 2 ☑ No		
ery injury of the traumatic event, the Medical Examiner count to notified at once.	Director	10e. Street and Number	L gomery	German	LOW	10f. Zip Code				10g. C	itizen of What Co	ountry?		
181.50	a D	13210 Meander (	Cove Drive			20874	<b>,</b>			U	SA			
	Funeral	11. Marital Status	Armed Ford		13. V	Vas Decedent of H Yes, specify Cuba	ispanic Ori	gin? (Spec	ofy Yes or N	0-	14. Race - Ame Black, Whit			
	by F	1 ☑ Never Mamed 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	1	1	☐ Yes 2X No	Specify:				Specify:	ite		
	bel	15. Deceder	nt's Education	16a	Deced	ent's Usual Occup	ation			16b. I	WII Kind of Business			
W	pie	(Specify only higher Elementary/Secondary (0-12)	st grade completed) College (1-	4or 5+) C11G	(Give )	kind of work done of OO NOT use retired er Servic	during mosi  )  -	t of workin	g			,		
	Completed		2	Re	pre	sentative	<u> </u>			Cor	mputer			
	Be	17. Father's Name (First, Middle,							(First, Middle	, Maide	n Sumame)			
H	၉	Alvin Rudolph F  19a, Informant's Name/Relations		106	AA-DD-	- 4-1 (01			velyn	-				
		Leslie Dent/ St	,			g Address (Street a ammack Di						Zip Code)		
		20a. Method of Disposition		20b. Place o	Dispos	sition (Name of latory or other place	1		ote .		ocation - City or	Town, State		
2		1 ☐ Burial 2 ☒ Cremation 4 ☐ Donation 5 ☐ Other (S		tate	-	tan Crema	1	2/6/	2006	Ale	xandria,	VΔ		
		21. Signature of Funeral Service	Licensee		22	Name and Address	s of Facilit	v						
8		Max S	· 9		110	mple Trib 40 Rockvi	llle I	Pike;	Rocky	rille	emation e, MD 20	Center 852		
er	cal Examiner	Sequentially list conditions, if any, loading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	r as a consequence	ol).									
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1⊡Live birl 4□Pregna 9□Unknov		5 🗆	Ectopic pregnancy Other <i>(specify)</i>					23d. Date of del Month	ivery Day Year		
İ	ρ	Part II. Other significant condition Diabetes Mellitus		th but not resulting in	the un	derlying cause give	en in Part I.		_		use contribute to	the cause of death?		
	Completed								24a. Was	an	24b. Were au	itopsy findings available		
1	E						· · · · · · · · · · · · · · · · · · ·			ormed?	prior to de uh?	completion of cause of		
. 1	BeC	25. Was case referred to medica examiner?					26. Place	of Death	Check only	2□No one)	102.765	2 No		
1	၉	1√∑ Yes 2 □ No	Hospital: 1 🗆 Ing		tpatient		4 LI NUI	rsing Hom	e 5□Res	dence	6 X Other (Spec	city) scene		
1	<u></u>	27. Manner of Death 1XXNatural 5X3 Pendin	28a. Date of (Month,	Injury 28b. 1 Day Year)	lime of njury	28c. Injury Work			d. Describe	how inju	iry occurred			
1	Certification:	2 Accident investigned investigation investigat	not be 290 Place o	f Injury - At home, fa	rm atro		res 2 1		Of Logation (	Ctroot	and Alicenters and Co.	-10		
ı	ert	4 Homicide determ	building	, etc. (Specify)	mi, stre	et, factory, office		20	City or To	wn, Stat	e)	iral Route Number,		
	Medicai C	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the b Examiner: On the bas and manne	is of examination an	, death d/or inv	occurred at the timestigation, in my op	e, date and pinion, deat	d place, ar	nd due to the d at the time,	cause(s	and manner as d place, and due	stated. to the cause(s)		
	<b>⊠</b>	29b. Signature and title of certifie				29c. License	number			29d. Da	ate signed (Monti	h, Day, Year)		
1		Hatricial	1 amin	-HODE		OCME				Feb	ruary 2,	2006		
		- Julia	will	- JOHN	1									
		30. Name and address of person	who completed cause											
Stat		30. Name and address of person  31. Date filed (Month, Day, Year)	ATONICA-		. ^	111 Popp	Stre	et, E	Baltimo	ore,	Marylar	nd 21201		

DHMH 17 Rev 1/2001

			1 – For State Registrar	State of Ma	arylan		artment <i>tificate</i>			and M	lental Hy	/giene	06	04031
	Physic /Medi		1. Decedent's Name (First, Middle, Last PATRICIA R	XBERTS							2. Date of D Month		Year	3. Time of Death
	Examir		4a. Facility Name (If not institution, give	E AT T	HE	LAKE  last birthday)	4b. City, T	LIS	Location of	RY	0. Date of 0	h		MICO
	Funeral Director			M 2[25]	80	Yrs.		Days	Hours	Min.	8. Date of B (Month, D June 1	2,1925	Co	hplace (State or Foreign buntry) nsylvania
	anyland ehow	_	10a. State 10b. County			y, Town or Lo	cation							10d. Inside City Limits
	the M 28a-f	Director	Maryland Wicomico  10e. Street and Number		Sa1:	isbury	10f. Zip (	Oodo				10. 07	(110) . 0	1 X Yes 2 □ No
	3a or	100	105 Times Square				2180					USA	n of What Co	ountry ?
980	n 72 hours after death with the Maryland "naturel", or Itema 23s or 28s-f show edical Ezarphraf must be notifiled at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 ADivorced	12. Was Decedent I Armed Forces? 1 Tyes 2 XIN If Yes, Give Year or Dates:				ent of His fy Cuban	panic Orig , Mexican Specify:	gin? (Spe i, Puerto	ecify Yes or N Rican, etc.)	0- 14.	Race - Ame Black, White ecify: Wh:	e, etc.
5-0	72 ho 'natur	eted	15. Decedent's Edu (Specify only highest grad	cation e completed)		16a. Deced	kind of work	done di	tion urina most	of worki	ina	16b. Kind	of Business/	
21215-0036	filed within Hygiene. ther then " int, it a Me	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+)	Manaq	OO NOT use	e retired)			,	Food 9	Servic	
	調子等は	Be Co	17. Father's Name (First, Middle, Last)			Hanay	GL		18. Mothe	r's Name	(First, Middle	<del></del>		
ylar		ToB	Elwyn Winne					i	Mable	e Lav	wlor			
Maryland	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Ty	pe, Print)		1					Il Route Numb			Zip Code)
	1 an 1 an 1 am 2		Chris Roberts/Son 20a. Method of Disposition		20b. P	dace of Disposemetery, crem				_	y, Mary		21804 ion - City or	Town, State
OM.	Pages nent of int: if it iry or o		1 ☐ Burial 2 🛣 Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	emetery, crem .isbury			1	2/1/0	<b>1</b> 6			aryland
Baltimore,	permit. Pages Department of P Important: if Its eny injury or of		2 Signature of Funeral Pervice Vicense	200	Juli	HO	Name and	Address V Fu	of Facility	Ног	me P.A. alisbur			2:
			23a. Part . Enter the disease, or complished, or heart failure. List only or	cations that called	th ceath	n. Do not ente							-	Approximate Interval Between
	Pnysician /Medical	r i	Immediate Cause (Final disease or condition resulting in death)	Croco	nn	Ohst	whi	1	n /	015	lac			Onset and Death
	Examiner			Due to (or as a	Deservi	nce of);		A)=	0	0.00				- /-
1	NEE S	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	uence of):			9.53					-
	ecuted and transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last											
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687	ficate p phys	edical												
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 27 No 9 ☐ Unknown	3c. If yes, outcome of 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3	Ectopic preg Other <i>(spec</i>					23d	. Date of deli Month	ivery Day Year
0	w requires that been signed b should be deta	by	Part II. Other significant conditions cor	tributing to death bu	t not resu	ulting in the un	derlying cau	use given	in Part I.		23e. Did	tobacco use		the cause of death?
Il Records,	The law recate has been page 2 sho	Completed									24a. Was auto perfo 1 Yes		4b. Were au prior to death?	topsy findings available of cause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:						of Death	(Check only	one)		/
oţ	Phys or this oral di	): To	1 Yes 2 No	28a. Date of Injur	/	ER/Outpatient 28b. Time of			4 🔲 Nuli		ne 5 🗆 Resi			cify)
ion	Attending I r death. ector: After by the funer	atlo	Vatural 5 Pending investigation	(Month, Day	Year)	Injury	М	c. Injury a Work? 1 🗌 Ye	s 2 🗆 N			,,		
Division of	in Signature	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju building, etc	ry - At ho . (Specily	me, farm, stre	et, factory,	office		2	28f. Location ( City or To	Street and N wn, State)	umber or Ru	ral Route Number,
	To the Hospital or within 24 hours after the Funeral Dirac ompletely filled in It	Medical	29a Certifier Check only one) Certifying Physical Examination (Check only one)	ician: To the best of er: On the basis of and manner stat	examınat	wledge, death ion and/or invi	occurred at estigation, in	the time n my opir	, date and nion, death	l place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as	stated. to the cause(s)
	of Twith	2	29b. Signature and title of confiler	1/11	Ι.	4.1	29c.	License r	number		0	29d. Date si	gned (Month	n, Day, Year)
	3		30. Name and address of parent who are	moleted course of	M ath (last	230)	leint)	0 0	16.	27	8	1 -	31-0	06
100	Sta	100°	30. Name and address of person who co  Out of E. Colladia  31. Date filed (Month, Day, Year)	32. Registra	al f	165 pic	P	d E	BX 12	733	Sali	54,	MD	21862
	Registr		JAN 3 1 20			H. So	anti)							

hysic? Medi/	ian.	Decedent's Name (First, Middle, La.	Patrick	Joseph	Rubilotta	a	2. Date of Dea Month	ith Day	Year	3. Time of Death
/IVIC G		Patrick Joseph			7		Januar	y 25, 20	006	5:36 A
Exami	ner	4a. Facility Name (If not institution, give				Location of Death		4c. County		
		1787 Rochester  5. Social Security Number 6. S		In yrs. last birthday		fton If Under 24 Hrs.	8. Date of Birth	Anne		
neral ector			RM 2□F	76 Yrs.	Months Days	Hours Min.	(Month, Day Dec. 19	(, Year)	Nww	lace (State or Fore try)
•		Usual Residence of Decedent					Dec. 19	1343	TAARAA	TOLK
Till Di	_	10a. State 10b. County		0c. City, Town or L					1	0d. Inside City Lim
all l	Director	Maryland Anne Aru	ndel	Croft						1 □ Yes 2 🙀
other traumatic event, the Middical Examinar must be notified at	급	10e. Street and Number 1787 Rochester S	+		10f. Zip Code	21114		10g. Citizen of V		ntry?
EME	by Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S. 13			ecify Yes or No-		JSA e - Americ	an Indian
i i	표	1 □ Never Married 2X Married	Amed Forces?	Λrmsz	Was Decedent of Hill If Yes, specify Cubar	n, Mexican, Puerto	Rican, etc.)	Blac	k, White,	
	by	3 ☐ Widowed 4 ☐ Divorced	1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 9	51-53	1 ☐ Yes 2 ☑ No	Specify:		Specify	· Wh	ite
Teg.	Completed	15. Decedent's Ed (Specify only highest gra	ucation de completed)	16a. Dece	edent's Usual Occupa e kind of work done d	ation	ina	16b. Kind of Bu	ısiness/Inc	dustry
	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired)	0	,,g			
		17 Father's Name (Circl Middle Leas)	4 Yrs.		General Er				Govt.	
9 / 6	Be	17. Father's Name (First, Middle, Last) Pasquale Rubil	otta			18. Mother's Name	e (First, Middle, ria Olce		Θ)	
á	P.	19a. Informant's Name/Relationship (7		10h Mail	ing Address (Street a				Ctata Zin	Code
Tau		Dorothy M. Rub	• • • • • • • • • • • • • • • • • • • •		87 Rochest					C008)
other		20a. Method of Disposition		20b. Place of Dispo	osition (Name of	! .		20c. Location -		wn, State
any injury or other tr. once.		1 □ Surial 2 □ Cremation 3 □  1 □ Donation 5 □ Other (Specify			matory or other place Mem. Gard		8-06 I	Davidson	will	e. MD
in in		21. Signature of Funeral Service Licen	_ I		2. Name and Addres					-,
any ir		* Juanard	X. DIGI	(ton 6:	512 NW Cra	in Hwv	II Funer Bowie,	rai Home MD 207	<u>፡</u> 715	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that caused the	death. Do not en						Approximate Interval Between
iai I:		Immediate Cause (Final disease or condition	Lung Can							Onset and Death
cal		resulting in death)	a. Due to (or as a c							
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	iclan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Date Mor		ry Day Y <i>e</i> ar
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	edical Certification; To Be Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1	Hospital:  28e. Place of Injury building, etc. (3)	Petal death 3 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 5 Le of death 6 Le	other (specify)  Inderlying cause give  Int 3 DOA Other  Of 28c. Injury Work  M 1 Y  reet, factory, office	26. Place of Death 37. 4 \( \to \) Nursing Hor at 7. fes 2 \( \to \) No	24a. Was a autops perform 1 Yes 7 autops perform 1 Yes 7 autops 28d. Describe house 28d. Describe house 28d. Location (St. City or Town	Mor bacco use contr es 2 □ No  In 24b. V Single med? d d d d d d d d d d d d d d d d d d	nth  3 Proba  Nere autoprior to comfeath? Proba  Prof (Specify)  ed  er (Specify)	Day Year  e cause of death?  ably 4 Unknow  by findings availab inpletion of cause of 2 No  7 Route Number,
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	Physici	ian	Decedent's Name (First, Middle, Last	ichards							2. Date of Dea Month Januar		,2006	ar	3. Time of Death	м	
	/Medic Examir		4a. Facility Name (If not institution, give Holy Cross Hospi	street and number)					Location o		Januar,	4c.	,2006 County of D	Death	8:00PM'		
	Funeral Director			ex 7. Ago CM 2□F	9 (In yrs. 12 38	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birt (Month, Da Dec 1	h y, <sub>Year)</sub> 1 194	.917 <sup>9.</sup>	Birthp Coun Vir	ace (State or Foreig Try) Sinia	gn	
	ne Maryland Ba-f ahow	ector	Usual Residence of Decedent  10a. State 10b. County  DC None			Town or Lo	n								od. Inside City Limit 1 ☐ Yes 2 ☐ N		
	th with the 23a or 2 ast be n.	Funeral Director	10e. Street and Number 5823 14th Street	NW #101			10f. Zip 20	011					zen of Wha ted S		•		
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show say highty of other traumatic avant, the Medical Examinar must be notified at once.	by Funer	11. Marital Status  1   ↑ Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Xes 2 1 If Yes, Give Year or Dates:	Ever in U.S nknow	n 13.	Was Deced If Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:		ecify Yes or No- Rican, etc.)		Black, \	ace American Indian, ack, White, etc. ify: White			
21215-0036	within 72 horene. then "nature he Medical B	Completed by	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)			(Give	dent's Usua kind of woi DO NOT us	k done a	luring mos	t of work	ing	Pela Comp	nd of Busin ASKi l Dany	ess/Inc Pail	ustry nting		
yland 2	ould be filed Mental Hygid arked other atic event, I	To Be Co	17. Father's Name (First, Middle, Last) 18.							18. Mother's Name (First, Middle, Maiden Surnar Unknown							
Man	nd 2 sho alth and 27 is m				dian	19b. Mailir 5819	ng Address 14th	(Street a	Ind Numbe	7 or Rura 7101	al Route Numbe Washing	gton,	Town, Sta	te, <i>Zip</i> 2001	Code) 1		
Baltimore, Maryland	Pages 1 and of He int: if item				20b. Place of Disposition (Name of cemetary, crematory or other place)  Date 20c. Location - City												
Balti	permit. Departmine imports any inju		21. Signature of Funeral Service Licen	a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State													
	Physician /Medical Examiner		23a. Part1. Ent in e disease, shock, if his rt failure. List only immediate Caus. (Final disease or condition resulting in death)	lications that caused ne cause on each line.  a. Pneumon  Due to (or as	ia	Do not ent	er the mod	e of dying	g, such as	cardiac (	or respiratory ar	rest,			Approximate Interval Between Onset and Death		
8760,	The law requires that the death certificate be executed sie has been signed by the attending physicien and cage 2 should be detached for use as the burial-transit.	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intitated events resulting in death) Last	b. Due to (or as conditions)  Due to (or as conditions)													
P.O. Box 6	the death certifica y the attending ph ached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		Ectopic pregnancy Other (specify)					23d. Date of delivery Month Day Year							
	w requires thet the de been signed by the a should be detached t		Part II. Other significant conditions of Dehydration, Rena				nderlying c	ause give	n in Part I.			obacco us		te to th	e cause of death? ably 4 Xunknow	'n	
Division of Vital Records,		Completed by								_	24a. Was autop perfo 1 Yes		prior	rto con th?	osy findings availab ipletion of cause of 2 No	le	
Vit	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1X Inpatie	nt 2□ E	R/Outpatier	nt 3□ DO	A Othe			n <i>Ch</i> eck onl√ o me 5 ☐ Resid		i∏Other (	Specify	)	-	
ion of	ding After funer		27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Da)	у	28b. Time of Injury		8c. Injury Work			28d. Describe h				<u>,                                     </u>		
Divis	et or Atte s after de i Diracto id in by th	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injubuilding, etc			eet, factory	, office			28f. Location (S City or Tou			or Rura	Route Number,	_	
	To the Hospitet or Attending I within 24 hours after death.  To the Funeral Director: After completely filled in by the funer	edical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exen	ysician: To the best of niner: On the basis of and marrier sta	examinati	rledge, deatl on and/or in	h occurred vestigation,	at the tim	e, date an inion, dea	d place, th occurr	and due to the o	cause(s) date and	and manne place, and	er as st	ated. the cause(s)	-	
)	To the training of training of the training of	M	29b. Signature and title of certifier	Ma			290	. License	number 32332				e signed (A nuary		, 2006		
	\		30. Name and address of person who Sumesh K. Gupta,					#220	) Si	lver	Spring						
	Sta	ate	31. Date filed (Month, Day, Year)	32. Fegistra			acti										

			1 - For State Registrar	State	of Marylan		artmen rtificate			and Me	ental Hy	giene	nnc	(	04034	
	Physici	an	1. Decedent's Name (First, Middle, I	•							2. Date of De Month	Day		ear	3. Time of Death	
	/Medic Examin		Geraldine Lillia  4a. Facility Name (If not institution, g				4b. City,	Town, or	Location of		Januar		27, 2006   10:40 A M			_
			Beverly Healthca	are				deri			Frederic			ick		
	Funeral		, , , , , , , , , , , , , , , , , , , ,	Sex 1 ☐ M 2XIF	7. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	B. Date of Bir (Month, Da	ıy, Year)		Count		
	Director		579-20-8220 Usual Residence of Decedent		83					A	ug. 18	3, 19	)22   Y	Wash	ington, D	<u>C</u> _
	nyland show		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						d. Inside City Limits			
	he Ma 1888-fs	Directo	Maryland Frederic  10e. Street and Number	k	Nev	w Marke	<del>-</del>								1 ☐ Yes 2 ☒ No	_
	with t		6530 North Shore	Uax			10f. Zip	21774	<i>'</i> .			_	izen <i>o</i> f Wha ced Si		,	
	death	Funeral	11. Marital Status	12. Was Dec	edent Ever in U	.S. 13.	Was Deced	ent of His	spanic Orio	gin? (Spec	ify Yes or No	· · · · · · · · · · · · · · · · · · ·	14. Race -	America	an Indian,	
0	or ite	y Fui	1 ☐ Nøver Married 2 ☐ Married	Armed F 1 ☐ Yes If Yes, G	2 🔂 No		if Yes, spec 1 ☐ Yes 2			, Puerto H	ican, etc.)	:	Black, Specify:	White, 6	tc.	
213-0030	hours tural',	ed by	3 ☐ Widowed 4X Divorced  15. Decedent's	Year or I	Dates:	16a. Dece					-	16h Ki	ind of Busin	Whit		_
0	nin 72  Medic	Completed	(Specify only highest of Elementary/Secondary (0-12)	rade completed,	) (1-4or 5+)	(Give	kind of wor DO NOT us	rk done d	uring most	of working	7	180. KI	nu or busin	nessina	ustry	
7	ad with	Com	12		(1-401 5+)	Sale	es Cle	erk				F	Retai	1		
and	be fill ntal Hy ad oth avant	Be	17. Father's Name (First, Middle, La								First, Middle					
2	hould id Mer marks matic	2	Irving R. Armstro  19a. Informant's Name/Relationship			19h Mailir	no Address	(Street a			Billir Route Numb			ate Zin	Code)	
Ma	nd 2 salth an 27 is rtrau		Ms. Nancy Brengs	(Daugh	ter)						ew Mar					
pailimore,	of Hee		20a. Method of Disposition		20b. F	Place of Dispo				Da			cation - Ci			
Ĕ	Page ment and: H		1 X Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spec		State	tlett :	Metho	dist	Cem.	1/3	0/2006	Ca	ıtlet	t, V	irginia	
Da	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment if it am active and into the result of items 23s or 28s-f show any injury or other traumstic avent. It is hedical Exeminer must be notified at once.		21. Signature of Funeral Service Lic	ansper	/	1	Name and Eastaithe	d Addres st De ersbu	s of Facility eer Pa irg, N	y DeV ark D MD 20	ol Fur rive 877	neral	. Home	Э		
¥	Hrysician		23a. Part 1 Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition	ly one cause on	caused the deat each line. ilure to			e of dying	g, such as o	cardiac or	respiratory a	rrest,			Approximate Interval Between Onset and Death Weeks	
	/Medical Examiner		resulting in death)	_	(or as a conseq										WEEKB	
	LAGIIIIICI	7	Sequentially list conditions, if any, leading to immediate cause Estat Underlying		o Natre									Weeks		
	uted d ansit	Examiner	Cause (Disease or injury that initiated events													
5	e exec ien an ırial-tr	that influed events c.    Column   Colu														
00/00	icate be executed physicien and s the burial-transit	dical	•	d												
יי אמ	death certific attending p	Physician/Me	IF FEMALE:	23c. If yes, ou	utcome of pregna	ancy							23d. Date d	of deliver	v	
ַ בַּ	that the death cer ed by the attendir detached for use	iciar	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No	1⊡Live 4⊡Preg	birth 2 ☐ Feta nant at time of d	Ideath 3□	Ectopic pro Other (spe					1	Month		Day Year	
)	at the by the tacher	hys	9 Unknown	9□ Unkr												
ָר ל מילי	w requires tha been signed I should be det	þ	Part II. Other significant conditions	contributing to c	death but not res	ulting in the u	nderlying ca	ause give	n in Part I.						e cause of death?	
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	itan: artifica ctor, p	BeC	25. Was case referred to medical examiner?						26. Place	of Death (	Check only			103	2 1 1 1 0	-
>	Pnysician: rthis certific ral director,	۵,	1 ☐ Yes 2X No		Inpatient 2			and the same of	4 LAINUI		e 5 ☐ Resi					
	en fite	ation:	27. Manner of Death  1   Natural 5 □ Pending 2 □ Accident investigat	on	of Injury 1th, Day Year)	28b. Time of Injury	M 2	8c. Injury Work 1 □ Y	at ? ′es 2□N		d. Describe	how injun	/ occurred			
	tal or Att	Certification;	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	d 286. Place	e of Injury - At ho ling, etc. (Specif	ome, farm, str	eet, factory	, office		28	f. Location ( City or To			or Rural	Route Number,	
	lo tha Hospital or Avanding within 24 hours after death.  To tha Funeral Director: After completely filled in by the funer	Medicai (	29a. Certifier 1	aminer: On the b	e best of my kno casis of examina nner stated.	wledge, death tion and/or inv	occurred a vestigation,	at the time in my op	e, date and inion, deat	d place, an	d due to the f at the time,	cause(s) date and	and manne place, and	er as sta d due to	ited. the cause(s)	
	- 5 - 0	ž	29b. Signature and title of certifier				29c	. License	number			29d. Date	e signed (/	Month, E	Pay, Year)	
	2		SIMA				D	0047	951			Janu	uary :	27,	2006	
			30. Name and address of person wh					110	Frada	ari al-	ML 3	1701	_/.510	)		
	Sta	te	Sibte A. Kazmi, 31. Date filed (Month, Day, Year)	32 <b>4</b>	Registrar's Signa	nouse	Aven	iue,	rreae	FLICK	, MD 2	1/01	-4519	,		-
	Registr	_	JAN 30	2006	some I	a John										

			1 - For State Registrar	State of	Marylan		artment of F rtificate of		ınd Me		iene	006		035
Ī	Dhusisi	p	1. Decedent's Name (First, Middle,	Last)					2	Date of Deat		Year	3. Time	of Death
	Physici /Medio		JOHN M. RUFFNER J	R.						JANUARY			8:0	00 A M
	Examin	er	4a. Facility Name (If not institution,		oer)		4b. City, Town, o	or Location of	Death		4c. C	County of Dea	th	
12	- K.	40	9805 COTTRELL TERR				SILVER S		2231			NTGOMER		
	Funeral		5. Social Security Number 577-26-2654	5. Sex 7. 1 1 M 2 □ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	Hours	Min.	Date of Birth	Year)		thplace (State	-
	Director		Usual Residence of Decedent		83					9/23/192	.2	WAS	HINGTON	DC
	ehow		10a. State 10b. County		10c. City	y, Town or Lo	cation		-				10d. Inside	City Limits
	Mar Mar	tor	MARYLAND MONTGOM	ERY	SII	LVER SPR	ING						1 🗆 Y	es 2 🛚 No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	en of What C	ountry?	
	th wi	a	9805 COTTRELL TERR	ACE			20903				U	SA		
	r dea	Funeral	11. Marital Status	12. Was Deced Armed Force			Was Decedent of F f Yes, specify Cub	lispanic Origi an, Mexican,	jin? (Specif Puerto Ric	y Yes or No-	14	4. Race - Ame Black, Whi	merican Indian,	
36	or it	by Fu	1 Never Married 2 Marrie	If Yes, Give	T.TI.IT T		1 ☐ Yes 2 🔯 No				s	Sancihe:		
Ö	hour:		3 Widowed 4 Divorced	Year or Date	es: WWII	100 0000	deede Herrel Ore					. WI	HITE	
5	within 72 hours after death with the Maryland ane than 'natural', or items 23a or 28a-f ehow the Mastical Exercities must be notified at	Completed	15. Decedent's (Specify only highest			(Give	dent's Usual Occup kind of work done DO NOT use retire	during most	of working		16b. Kind	d of Business	/Industry	
72	thar thar	mo	Elementary/Secondary (0-12) 12	College (1-4	lor 5+)		S OPERATOR	-7			IBM	IBM		
פַ	be filed tal Hygie d other event, II	BeC	17. Father's Name (First, Middle, La	rst)				18. Mother	r's Name (F	First, Middle, M	Maiden S	lumame)		
lar	should be filed within 72 hours after death with the Maryla of Mental Hygiene. marked other than "natural", or liems 23a or 28a-f ehov matic event, the Madical Existificat must be nutified at	ToB	JOHN M. RUFFNER SE	₹.				DAI	ISY DEC	CK				
Mary	12 sho h and h 7 Is me traume	İ	19a. Informant's Name/Relationship DOROTHY RUFFNER - V				g Address (Street OTTRELL TEI						Zip Code)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should bu Department of Health and Menta Importent: If Item 27 Is marked eny injury og other traumatic ev		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	I Domewal from St			sition (Name of natory or other plai	ce)	Date	е ;	20c. Loca	ation - City or	Town, State	
<u>ti</u>	rtment rtment: rtent: I		4 □Donation 5 □ Other (Special Service Lie	city)			INGTON CEM	-		006	ADEL	PHI, MD		
Ba	Depa Impo eny i		Myelin Till	lele I		1:	. Name and Addre	AMPSH <b>I</b> RE	HINE E AVE;		SPRING			
	Physician		23a. Part1. Enter the disease, or conshock, or heart failure. List or immediate Cause (Final	nly one cause on eac	th line.		er the mode of dyir	ng, such as c	cardiac or r	espiratory arre	est,		Approxin Interval I Onset ar	3etween
) ; ;	/Medical		disease or condition resulting in death)	a	RDIAC AT									
20	Examiner		Convention list and the sec	b SM	ALL-CELI	L CARCIN	OMA OF THE	LUNG					8 YEAI	RS
	D =	ner	S quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or										
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8760,	cien a	E	rooding in doding East	,	as a consequ	,	OD A TILLY						10 115	. D. G
687	ificate be executed g physicien and as the burial-transit	edical		d. 15	CHEMIC (	CARDIOMY	OPATHY						10 YE	ARS
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О	at the de by the a	hysi	1	9□ Unknow	n									
Records, 1	The law requires that the death certificate be executed to has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	ρ	Part II. Other significant condition SEVERE COPD	s contributing to deal	th but not resu	ulting in the un	derlying cause giv	en in Part I.				e contribute to		
ဝင္	e taw requ has been je 2 should	plet								24a. Was ar		24b. Were at	itopsy finding	gs available
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Vital	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	7				26. Place o	of Death (C	Check only one			21	
	Physi this c	٩	1 ☐ Yes 2 ☒ No		atient 2 1			4 17013		5 🛚 Reside			city)	
Division of	rng I	Certification:	27. Manner of Death  1 □XNatural 5 □ Pending 2 □ Accident investigal		Day Year)	28b. Time of Injury	28c. Injur Wor	yat k? Yes 2 ⊡ No		f. Describe ho	w injury (	occurred		
NISI VISI	Attendi or death. ector: A by the fu	Iffica	3 Suicide 6 Could no determine	be 28e. Place of	Injury - At ho	me, farm, stre	eet, factory, office			Location (Str		Number or Ri	ural Route N	umber,
	Hospitel or Att				, etc. (Sp <i>ecity</i>					City or Town				
	To the Hospitel within 24 hours a To the Funerel I completely filled	edical	29a. Certifier 1 X Certifying (Check only one)	Physician: To the be aminer: On the basi and marine	s of examinat	wledge, death ion and/or inv	estigation, in my o	ne, date and pinion, death	place, and n occurred	I due to the ca at the time, da	iuse(s) ar ate and p	nd manner as lace, and due	s stated. e to the cause	e(s)
	To the within 2 To the comple	×	29b. Signature and title of certifier	7.1			29c. Licens			29		signed (Mont		)
•	5			W			D280	003			1/	26/0	6	
			30. Name and address of person which LESZEK FIUTOWSKI	M.D. 9051			Print) E; COLLEGE	PARK MD	20740	)		,		
18 E	Sta		31. Date filed (Month, Day, Year)		istrar's Signar									
	Registra	ar	JAN 30	2006	we way	Page 1								

			For State Registrar		State of M	larylan		artment <i>rtificate</i>			d Mental H	ygiene Reg. Ne	'HHE	04036		
	2 5 · · · · ·	7 L	Decedent's Name (First	t, Middle, La	ast)						2. Date of I	Death		3. Time of Death		
1	Physici /Medio		James Harry	Raymo	and Jr.						Month O	24	o Zox	20:00PM		
	Examir		4a. Facility Name (If not in			r)	2	4b. City, T	Town, or Lo	ocation of De			County of Death			
13		, 630.	teninala	Ragio	nac Medi	in Ce	enter		Salis	Stury	1		WICONIC	Ò		
44.	Funeral		5. Social Security Number		Sex 7. A 1 X M 2 ☐ F	ige (In yrs. I		If Under 1 Months		If Under 24/F	frs. 8. Date of E	Day, Year) Country)				
S.	Director		222-05-7718		I EST WI SCILL	90	Yrs,				Januar	y 22	,1916 Del	laware		
	and and		Usual Residence of Dece 10a. State 10b.	County		10c. City	r, Town or Lo	cation					1	0d. Inside City Limits		
	Maryi 1 ehc	ō	Maryland Wi	comic	0	Sal	isbur	J.						1 X Yes 2 □ No		
	28a	rec	10e. Street and Number					10f. Zip (	Code			10g. Ci	itizen of What Cour	ntry?		
	72 hours after death with the Maryland natural', or Itame 23a or 28a-f ehow dical Examiner must be notified at	Funeral Directo	1004 Heron	Court				218	04			τ	JSA			
	ms 2	Jere	11. Marital Status		12. Was Deceden	t Ever in U.	S. 13.	Was Decede	ent of Hisp	anic Origin?	(Specify Yes or I lerto Rican, etc.)		14. Race - Americ			
9	or Ita	Fu	1 Never Married 2	Married X	Armed Forces 1 Yes 2 K			_		Specify:	ieno Rican, etc.)		Black, White,  Specify:	etc.		
933	iral'.	10a. State   10b. County   10c. City, Town or Location							LAND V	Specily.	te					
21215-0036	natu dica	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during me							on ring most of v	working	16b. K	Kind of Business/In	dustry			
121	Mithin noe. than	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  12  College (1-4or 5+)  Accountant									D					
	filed withi Hygiene. other than		12 17. Father's Name (First,	Middle, Las	,,		Accou	ncanc	18	8. Mother's N	Name (First, Midd		ont Sumame)			
an	ould be Mental arked o	Be c	James Harry		01 !!						, marao	, , , , , , , , , , , , , , , , , , , ,				
Maryland	2 shoutd and Men Is marke sumatic	2	19a. Informant's Name/R		DE:	19b. Mailing Address (Street and Number or Rural Route N							or Town, State, Zip	Code)		
	nd 2 lith a 27 Is r trau		Barbara Ray	nond/V	Wife or St	ouse					isbury,					
Baltimore,	permit. Pages 1 and 2: Department of Health ar Important: If Itam 27 Is eny injury or other trau		20a. Method of Dispositio		•	20b. PI	lace of Dispo emetery, crei	sition (Nami	e of	Ī	Date	20c. L	ocation - City or To	wn, State		
E	Page nent c nt: If rry or		1 ☐ Burial 2 🗷 Cred 4 ☐ Donation 5 ☐ 0			θ	.isbur	•		v 1/2	7/06	Sal	isbury, M	farul and		
alti	mit. partir ports ports y inju		21. Signature - 1 uneral	Service Lice	nsee	, DG.					Home P.A		TODULY / I	dryrana		
m	88 = 88		XPS	20.0	spell be		50	1 Sno	w Hil	ll Rd.	Salisbu	ry, M	Maryland	21804		
			23a Part . Enter the disc shock, or heart failu	ase, or con re. List only	plications that cause one cause on each	ed the death	<i>y</i> .	_						Approximate Interval Between		
Ves.	Enysician	1	Immediate Cause (Final disease or condition		Myor	ardi		Tate	wel	Han			0 41	Onset and Death		
	/Medical Examiner		resulting in death)	(	Due to (or a	s a consequ	ence of);				124 - 1	~ P.	-abscess	1		
	LAMINITE	L	Sequentially list condition	s,	b. Intest	had g	sceno	arc,	nome	a cu	iju colo	4164	-abs(ess (	fmaD		
	ed sit	Examiner	if any, leading to immedia cause. Enter Underlying Cause (Disease or injury	te 🐇	Due to (or a	s a cons	ience ot):									
	cate be executed physicien and the burial-transit	xan	that initiated events resulting in death) Last		c. Due to (or a	s a consequ	ience of):					-				
8760,	sicier buria	dical E		•												
687	ificate g phy as the	edic			_ d.											
Вох	anding use	Z M	IF FEMALE: 23b. Was decedent pregr	ant	23c. If yes, outcom			100					23d. Date of delive	iry		
	death e atte	lcla	in the past 12 month 1 ☐ Yes 2 ☐ No	s?	1□Live birth 4□Pregnant			Ectopic pre Other (spe				_	Month	Day Year		
P.0	that the death certifued by the attending I	Physician/Me	9 Unknown		9Ll Unknown											
	The law requires that the death certificate has been signed by the attending is age? Should be detached for use as	by	Part II, Other significant	conditions	contributing to death	but not resu	Iting in the u	nderlying ca	use given i	in Part I.	23e. Di	d tobacco	use contribute to the			
ord	and single	ted	Chronic	Lyou	MOCY I) C		COK	Ma			_ 10	Yes 2	!□No 3□Prob	ably 4 □Unknown		
Records,	ne taw r has be ge 2 sh	Completed by	Cordion	yopo	ethy						24a. Wi	topsy	prior to con	psy findings available		
		Con		/ '	0						pe 1 ☐ Yes	rformed?	death?	2 12 No		
Vital	cian: ertific ector,	Be	25. Was case referred to examiner?	medical					1 .	26. Place of D	Death Check only	one)				
of	Physician: r this certifica ral director, I	မ	1 Yes 2 700		Hospital:		ER/Outpatier						6 ☐Other (Specify	<i>y</i> )		
등	t ner	on:		Pending	28a. Date of Inj (Month, D	ay Year)	28b. Time of Injury		C. Injury at Work?		28d. Describ	e how inju	ry occurred			
isic	Attending in death ector: After by the fine	cat	2 Accident 3 Suicide 6	investigation Could not be	De Olana et la	aiun - At ho	mo tarm etr	M cot factors		s 2 No	29f Location	/Street a	nd Number or Rura	I Pouto Number		
Division	after after Direct	Certification:	4 Homicide	determined	building, e	tc. (Specify	)	eet, lactory,	onice			own, State		THOUSE NUMBER,		
	To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1	ertifying Pl	hysician: To the bes	t of my know	wledge, deat	occurred a	t the time.	date and pla	ace, and due to the	ne cause(s	s) and manner as si	ated.		
	P Fu	Medical	(Check only 2 □ N one)	edical Exa	miner: On the basis and manner s	of examinat	ion and/or in	estigation,	in my opini	ion, death o	ccurred at the tim	e, date an	d place, and due to	the cause(s)		
	withir To th comp	M	29b. Signature and little of	certifier	/	-		29c.	License n	number		29d. Da	ate signed (Month,	Day, Year)		
	2		Waid	C/	ellezar	, U	D	1	)446	88		Ju	L 27	2006		
	De la company de		30. Name and address of		completed cause of	death (Item	23a) (Type,	Print)	17.	David	Kerrice	AMA	1007			
_	W		560 Riversi		としていいか	te M	1906	Sal	1500	wy,	with	0	(00)			
	Sta Registr		31. Date filed (Month, Da)	( Year) N 3 0 2		trar's Signat	ure	-		0'						
7	hegisti	al	UM	Y O U	CUUD RAM	ARD A	7. Ja	324/15								

DHMH 17 Rev 1/2001

322-05.7718

James H. Raymond

			1- For Amended line	State of #5 per	Marylan fh/t1	nd / Depa	artmer	nt of H	lealth a Death	and M	ental Hyg	giene	006	5 0	400	3 7
			Decedent's Name (First, Middle, Last		2/2	700					2. Date of Dea	ath			3. Time of 0	Death
	Physici /Medic		Kristine Marie Ri	.ley							Month January	28,		ear 6	3:12	P <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give		ber)		4b. City	, Town, o	r Location of	of Death		4c. (	County of	Death		
	1.95	*	412 Shannon Court		A //	to a to take to b	If I lada	Fred	erick		0.0			deric		J# 41
	Funeral Director			ex □M 2⊠F	. Age (In yrs. 36	Yrs.	Months		Hours	Min	8. Date of Birt (Month, Day Oct. 12	v Yearl	69 1	Birthplace Country Delaw	e (State or ) aro	Foreign
i.	Xy-		Usual Residence of Decedent							[	000. 12	, 17	07 1	DCIAW	are	
	rylan	_	10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d.	Inside City	
	8a-1:	ecto	Maryland Frederi	ck	F	rederi									1 <b>⊠</b> Yes	2 🗆 NO
	with It		10e. Street and Number 412 Shannon Court				10f. Zi	p Code	701			-		at Country	2"	
	ns 23	eral	11. Marital Status	12. Was Deced	ent Ever in U	S. 13.1	Was Dece			igin? (Spe	city Yes or No-	-		State		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show says injury or other traumatic event, the Madical Examinar must be notified at ance.	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Ford 1 Tes 2 Il Yes, Give Year or Dat	es? Mo		I Yes, spe	orfy Cuba	Specify:	n, Puerto I	Rican, etc.)			White, etc		
21215-0036	72 hou	Completed	15. Decedent's Ed			16a. Dece	dent's Usu	al Occup	ation during mos	t of worki	ng	16b. Kin	nd of Busin	ness/Indus	try	
2	iffin 7	nple	(Specify only highest gra	College (1-4	tor 5+)	life.	DO NOT	use retired	d)	il Or WOIKII	'g					
2	lygier her th		17 Februar Name (First Middle Least	2		Graph	nic A	rtis		ada klama	(First, Middle,		ertis			
anc	ntal Hed of	Be	17. Father's Name (First, Middle, Last) David Riley								Laffer		oumame)			
Maryland	should nd Me mark matic	၉	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	na Addres	s (Street			I Route Numbe		Town, St	ate, Zip Co	ode)	
Σ	nd 2 alth ar 27 is ritrau		Keith McIlwee / H	lusband		412 5	hann	on C	т. F	redei	rick, M	D 21	701			
re,	ss 1 a of Hea itam		20a. Method of Disposition		1 ,	Place of Dispo	sition (Na	me of	1		ry 30,			ity or Town	, State	
<u>Ĕ</u>	Page ment c ant: if ury or		1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification)			thaven				200	06	Fred	erick	k, Ma	rylan	.d
Baltimore,	permit. Departimport import any inj		21. Signature uneral Service Licer	see	-	Re 95	Name a stha	nd Addre Ven atoc	ss of Facilit Funer tin M	al Se	ervices Hwy. Fr	, Ski	kot (	Cody 1 MD 2	P.A. 1701	
			23a. Part1. Enter the disease, ar com shock, or heart failure. Just only	plications that car one cause on ear	used the deat ch line.									Ap	oproximate terval Betw	veen
	Physician		Immediate Cause (Final disease or condition	a. Myocar	dial I	schemi	a								nset and D 1°C	eall1
	/Medical Examiner		resulting in death)		ras a conseq											
		J.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to for	r de a coneso	uence att:										
	nsit	nlne	Cause (Disease or injury	2001010	- us u - c - is c -	provide Org.										
<u> </u>	execu n and ial-tra	Exal	that initiated events resulting in death) Last	c Due to (o	r as a conseq	juence of):								_		
8760,	ficate be executed physicien and is the burial-transit	dical Examiner		d												
9	rtifica ng ph as th	Medi	IF FEMALE:													
Вох	The law requires that the death certific Ite has been signed by the attending p age 2 should be detached for use as	Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	ome of pregna th 2 ☐ Feta		Ect <i>o</i> pic p	pregnancy	,			2	3d. Date o	,	w Y	ear
o.	he dea the al	/sicl	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnai 9∐ Unkn <i>o</i> v	nt at time of d vn	leath 5	Other (s	pecify) _					WORK		iy i	Ģ <b>a</b> i
٥.	that the ded by detac	Ph	Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the u	nderlying	cause div	en in Part I	l.	23e. Did to	obacco us	se contrib	ute to the	cause of de	eath?
ds,	uires sign	d by	Metastatic Bre			•	,,,,,	<b>3</b>			101	/es 2[	]No 3	Probabl	ly 4 <del>∏</del> U	nknown
CO	w require been sign should b	lete	Cancer Cachexi								24a. Was	an	24b. We	ere autopsy	findings a	ıvaılable
Be	The la te has age 2	duo	Gancer Gachexi	а								rmed?	prio	or to compl ath? Yes 2	letion of ca	use of
ta	an: T	a)	25. Was case referred to medical						26. Place	e of Death	1 Yes	1000	- '-	ires 20	⊒ No	
>	Attending Physician: r death. ector: After this certifice by the funeral director, p	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🗌 Inj	patient 2	ER/Outpatier	nt 3 🗆 🗅	OA Oth	er: 4 🗆 Nu	ursing H <i>o</i> r	ne 5√AResid	dence 6	Other	(Specify)		
0	ng Pt fter tt ineral		27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	1	28c. Injur Wor			28d. Describe f	now injury	occurred	d		
sio	tendi leath. tor: A the fu	catl	2 Accident Investigation 3 Suicide 6 Could not be				М		Yes 2			•				
Division of Vital Records, P.O.	i or At after o Direct I in by	Certification;	4 Homicide determined	28e. Place o	f Injury - At h g, etc. <i>(Specil</i>	ome, larm, str fy)	eet, facto	ry, office		1	28f. Location (S City or Tow			or Hural H	oute Numi	ber,
	To the Hospital or Attending Physician: The law within 24 brouns after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical C	2nd Certifier 1K, Certifying Ph (Check only one) 2 Medical Examona)	ysician: To the b niner: On the bas and manne	is of examina	wiedge, deall ation and/or in	n secure. vestigatio	at the tr n, in my o	ne date an pinion, dea	id place, t	and due to the	causu(s) date and	and man place, an	er as state d due to th	d. e cause(s)	
	To the within 24 To the Complete	Me	29b. Signature and title of certifier	- manife			29	c. Licens	e number			29d. Date	signed (	'Month, Da	y, Year)	
	> - 0		DAT. H	FGA	Zi, W	0		D 44]	164			Janus	arv 3	30, 20	006	
	610		30. Name and Iddress of person who	completed cause	of death (Iter	п 23а) (Туре,				-				- ,		
	200		A.Z. Hegazi, M				son ]	Drive	e, Fre	ederi	.ck, MD	2170	)2			
	Sta Registr		31. Date filed (Month, Day, Year)  JAN 3 1		strar's Signa	ature	Com	Es .								

			1 - For State Registrar	State of I	Maryland /		artmen tificate			ınd M		giene Reg. No.	006	04038
1	Discontact		1. Decedent's Name (First, Middle	, Last)							2. Date of De. Month	ath Day	Yeer	3. Time of Death
	Physici /Medic		John James Rile	ey							January			11:50p₩
	Examin		4a. Facility Name (If not institution	, give street and numb	er)		4b. City,	Town, or	Location o	f Death		4c. C	County of Death	h
\$ P	gc 1	,	Shady Grove Adv		pital Age (in yrs. iast	desired by all and all	Rocky If Under		e If Under 2	DA Hre	0. Date -( Die		ntgomer	<del></del>
	Funeral Director		5. Social Security Number 578–28–0786	11X M 2 □ F	77	Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da	y, Year)	Coi	nplace (State or Foreign untry)
	÷ :		Usual Residence of Decedent								July 22	19 19	ZO Wasi	iring con, DC
	how		10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	9 Ma	cto	Maryland Montgo	omery	Mont	gomei	cy Vi	llag	е					1 ☐ Yes 2 🖾 No
	or 2	Directo	10e. Street and Number				10f. Zip	Code					en of What Co	•
	after death with the Maryland or items 23a or 28s-f show or items 7 and be notified at	eral	19310 Club Hous	se Road  12. Was Decede	et Ever in H.C.	12 1	Mas Doord		886	in2 /Con			ed Stat	
	or item	Funeral	11. Marital Status  1 □ Never Married 2 □ Marri	Armed Force	s?	13.	f Yes, spec	offy Cuba	n, Mexican	, Puerto l	cify Yes or No Rican, etc.)	`   '	Black, White	
D 20	hours a tural', or	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Date	s:		1 ☐ Yes 2	2 X No	Specify:			3	Specify: W	Thite
2-003p	n 72 hours after death with the Marylar "natural", or lieme 23a or 28e-f ehow potest Examinan must be molified at	Completed	15. Decedent (Specify only highes	's Education	1	6a. Deced	dent's Usua	I Occupa	ation furing most	of worki	ng.	16b. Kin	d of Business/I	Industry
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N	be filed within tal Hygiene. Id other then event, it a M		17. Father's Name (First, Middle, I	5+		Atto	rney		10 Metho	do Nomo	(First, Middle,	Leg		
=	od of	Be											umame)	
2	should be nd Mental marked imatic ev	ဥ	John James Rile  19a. Informant's Name/Relationsh	-	1	9b. Mailin	na Address	(Street a			Wimber		Town, State, Z	in Code)
Z	od 2 s lith ar 27 to r trau		Karen Stinnett		- 1		_						, NC 28	
ē,	es 1 and 2 should of Health and Mer filem 27 le marke r other traumatic		20a. Method of Disposition		20b. Place					D	ate		ation - City or 1	
E E	Pages nent of int: If it		1 ☐ Burial 2 📆 Cremation 4 ☐ Donation 5 ☐ Other (S <sub>I</sub>		ile.				atory		ry 26,	Alex.	andria.	Virginia
a	permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service I	icensee		22	. Name an	d Addres	s of Facilit	, De	Vol Fur			,
0	40 E 5 8		Tobert &	Delot		G G	ithe	sbu	er Pa rg, M	5 <sup>K</sup> 20	877 <sup>e</sup>			
	;. Sir		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused in the cause on each	sed the death. I	Do not ent	er the god	e of dying	y, such as	cardiac o				Approximate Interval Between
F	hysician		Immediate Cause (Final disease or condition	a AC	ite Ke	SPi	relu	1 1	ail	ln	, .			3 weeks
48	/Medical Examiner		resulting in death)	Due to (or	as a consequen	ce of)		1	11	4	/	1	1:	onset and Death Sweets Zo Years.
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		new	en	Si				-			
ĵ	ate be executed thysicien and the burial-transit		resulting in death) Last	Due to Fr	as a consequen	ce of):	1.1		4	0	0			
00/9	cate be ohysicie the bur	Physician/Medical		La(	with	lev	et	16	W.	for	cke	· .		
Ď :	nding ph	Med	IF FEMALE:		V									
Š O	death ce	lan/	23b. Was decedent pregnant in the past 12 months?		2 ☐ Fetal de	ath 3□	Ectopic pre					23	3d. Date of delined Month	very Day Year
5	the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnan 9□Unknow	t at time of death n	າ 5∟	Other (sp	ecify)						,
ŗ	mar r ed by detac		Part II. Other significant condition	ns contributing to deat	h but not resultin	g in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	obacco us	e contribute to	the cause of death?
cords	ine law fedures mat me deain centific ate has been signed by the attending p bage 2 should be detached for use as:	d by									101	/es 2 □	No 3 Pro	obably 4 Unknown
S S	s been	Completed									24a. Was	an	24b. Were aut	topsy findings available
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	diffice	ø.	25. Was case referred to medical						26. Place	of Death	(Check only o	ne)	1 1 1 1 1 1 1 1	No
<u> </u>	nysic nis ce I direc	ToB	examiner? 1 ☐ Yes 2 🙀 No	Hospital: 1 XInp	atient 2 □ ER/	Outpatien	t 3 🗆 DO	A Othe	er: 4 □ Nu	rsing Hor	ne 5 ☐ Resid	dence 6	□Other (Spec	cify)
	Mer ti	ü	27. Manner of Death  1 XNatural 5 ☐ Pending	28a. Date of I (Month,	njury 281 Day Yeer)	b. Time of Injury	2	8c. Injury Work	at ?	2	8d. Describe I	now injury	occurred	
VISIO	for: /	cat	2 Accident investig	ot be			М		res 2□N		101.1			
<u> </u>	or A efter Direct in by	Certification:	4 ☐ Homicide determi	ned 286. Place of	Injury - At home etc. (Specify)	, raim, str	eet, factory	, office		4	City or Tov	vn, State)	Number of Hu	rai Route Number,
	spiral iours neral filled		29a. Certifier 1 Certifyin	g Physician: To the be	est of my knowled	dge, death	occurred a	at the tim	e. date and	d place, a	nd due to the	cause(s) a	and manner as	stated
:	to the hospital or Attending Prysician: Ind. within 24 hours effer death. In the Funeral Director. After this certificate in property filled in by the funeral director, pag	Medical	(Check only 2 Medical I	xaminer: On the basis	s of examination	and/or inv	vestigation,	in my op	oinion, deat	h occurre	ed at the time,	date and p	place, and due	to the cause(s)
1	The state of the s	×	29b. Signature and tute of certifier	2 1000			29c	License	number	,	0	29d. Date	signed (Month	Day, Year)
	(5)		25 HS9	C> VVV	)		1	0	06	4	5 9	1/	25/	2000
	5		30. Name and addless of person	who completed cause of	of death (Item 23	a) (Type,	Print)	11	1)	fr.	n D.	de u	161. M	D 20850
. 10			31. Date filed (Month_Day, Year)	32,000	OC 9	712	NIC	ch (	a le	nter	M NO	do	ing so	O CO 030
	Sta Registr		31. Date files (Month, Day, Year)	2006	strar's Signature	A.	arles							

Funder   Director	eath George Birthplace (State or Foreign Country) Liberia  10d. Inside City Limits 1 New 2 No Country?  merican Indian, thite, etc. Black ss/Industry  e, Zip Code) , Md. 20774
Prince George Hospital  Prince George Hospital  Prince George Hospital  Prince George Hospital  Prince George Hospital  S. Social Security Number  256-93-1665 6. See  1	George Birthplace (State or Foreign Country) Liberia  10d. Inside City Limits 1 News 2 No Country?  merican Indian, thite, etc. Black ss/Industry  e, Zip Code) , Md. 20774
Top   State   Top   State	Liberia  10d. Inside City Limits 1  Yes 2 No  Country?  merican Indian, hite, etc. Black ss/Industry  e, Zip Code) , Md. 20774
Maryland Prince Geo.  10c. City, Town or Location  Upper Marlboro  10c. Street and Number  1305 Merganser Ct.  11. Markal Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Figure 10.  13. Was Decedent of Figure 10.  13. Was Decedent of Figure 10.  14. Race - 11.  15. Was Decedent of Figure 10.  16. Specify:  16. Decedent's Equation (Specify: Specify: S	1⊠Yes 2□No  Country?  merican Indian, thite, etc.  Black ss/Industry  e, Zip Code) , Md. 20774
Elementary/Secondary (0-12)   College (1-4or 5+)   Home	merican Indian,  hite, etc.  Black ss/Industry  e, Zip Code) , Md. 20774
Elementary/Secondary (0-12)   College (1-4or 5+)   Home	hite, etc. Black ss/Industry  e, Zip Code) , Md. 20774
Elementary/Secondary (0-12)   College (1-4or 5+)   Homemaker   H	e, Zip Code) , Md. 20774
Physician //Wedical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician //Wedical Examiner  15	,Md. 20774
Physician //Wedical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician //Wedical Examiner  15	,Md. 20774
Physician /filedical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician /filedical Examiner  25a. Immediate Cause (Final disease or condition resulting in death)  25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Preumonia  25a. Preumonia  25a. Preumonia  25a. Due to (or as a consequence of):  Chronic Leukemia  25a. Due to (or as a consequence of):  Chronic Leukemia  25b. Chronic Leukemia  25c. Due to (or as a consequence of):  C. Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Chronic Leukemia  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Chronic Leukemia  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Obtain the past 12 months?  1   Ves 2    or Town, State	
Physician //Wedical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician //Wedical Examiner  15	Maryland
Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Physician //Medical Examiner  Sequentially list conditions, if any, leading to minediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death)  Due to (or as a consequence of):  Chronic Leukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Chronic Jeukemia  Due to (or as a consequence of):  Jeukemia  Jeu	tuary Inc. 20011
Sequentially list conditions, it airy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    Chronic Leukemia	Approximate Interval Between Onset and Death WEEKS
Due to (or as a consequence of):    Comparison of the control of t	Years
SPOON A REPORT OF THE PROPERTY	
So to to to to to to to to to to to to to	delivery Day Year
24a. Was an autopsy performed?  1   Yes   2 No   No   No    24b. Wern prior deat   1   Yes   2 No   No    24a. Was an autopsy performed?  1   Yes   2 No   No   No    24b. Wern prior deat   1   Yes   2 No   No    24b. Wern prior deat   1   Yes   2 No   No   No    25c. Was case referred to medical examiner?  1   Yes   2 No   No   No    1   Yes   2 No   No   No    1   Yes   2 No   No   No    25c. Was case referred to medical examiner?  1   Yes   2 No   No   No    25c. Was case referred to medical examiner?	
25. Was case referred to medical examiner?  1   Yes   2   No   No    1   Yes   2   No    25. Was case referred to medical examiner?  1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   2   No    1   Yes   Y	
Hospital: 1 Inpatient 2 XER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 5 Other/	
O E 5 d	oecify)
27. Manner of Death 1 Stratural 2 Accident 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 1 Yes 2 No 28c. Injury at Work? 28d. Describe how injury occurred 1 Injury M 1 Yes 2 No 28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number of City or Town, State)	Rural Route Number,
28e. Place of Injury: At home, farm, street, factory, office  28f. Location (Street and Number of City or Town, State)  28g. Certifier (Check only one)  29g. Certifier (Check only one)  29g. Signature and title of certifier  29g. Signature and title of certifier  29g. Signature and title of certifier  29g. License number  29g. License number  29g. License number	
7. 0105 60194 2006 0	as stated. ue to the cause(s)
30. Name an address of person who completed cause of death (Item 23a) (Type, Print) Walter Reed Army Medical C JALRUO HOLMES 6900 Ga. Ave, N.W., Wash, D.C.	onth, Day, Year)

			1 - For State Registrar	State	of Maryla	and / Depa <i>Ce</i>	artment o	f Health an of Death		giene 006	04040
			1. Decedent's Name (First, Middle	a, Last)					2. Date of Dea	ath	3. Time of Death
	Physici /Medio		John Thomas St	rain						Day Yea 7 23, 2006	4:15 A M
	Examir		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Tow	n, or Location of D		4c. County of De	
			150 Chevy Chas					ersburg		Montgom	ery
	Funeral		5. Social Security Number	6. Sex 1 XM 2 ☐ F		rs. last birthday)	If Under 1 Y Months Da		Hrs. 8. Date of Birt Min. (Month, Da	h y, Year) 9. E	Birthplace (State or Foreign Country)
	Director	Į	142-24-8855 Usual Residence of Decedent			72 Yrs.			March 4	, 1933 Ne	# Jersey
	land to the		10a. State 10b. County		10c.	City, Town or Lo	cation				10d. Inside City Limits
	Mary -fah	ğ	Maryland Montgo	ome <b>r</b> v	G	aithers	າມະດ				1 X Yes 2 ☐ No
	7.28a	rec	10e. Street and Number			areners.	10f. Zip Cod	de		10g. Citizen of What	Country?
	death with the Maryland ms 23e or 28a-f ahow Li wai ke nulling al	D	150 Chevy Chase	Street,	#206		2087	8		United Sta	ates
	deat	Funeral Director	11. Marital Status	12. Was De Armed F	cedent Ever in	n U.S. 13.	Was Decedent	of Hispanic Origin	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar	merican Indian,
٥	or ite		1 ☐ Never Married 2 🔀 Marr	ied 1 🔀 Yes	2 No 1	955-	1 ☐ Yes 2 🛣		deno Rican, etc.)	111	1ite, etc.
21215-0036	ural',	d by	3 Widowed 4 Divorced	Year or	Dates: 1	958	103 212	то эрвену.		Specify:	White
ភ្ន	"natu	Completed	15. Deceden (Specify only highes		1)	(Give	dent's Usual Od kind of work do	one during most of	working	16b. Kind of Busines	ss/Industry
V	withir than	E D	Elementary/Secondary (0-12)	College 4	(1-4or 5+)		DO NOT use re	tirea)		El cotaco	: 0
N	Hygie ther int,	ပိ	17. Father's Name (First, Middle,			Pres	Laent	18 Mother's	Name (First, Middle,		ics Company
yland	d be antal l	Be C	John Edward St	•					a Laffey	Walden Sumame)	
<u>-</u>	Shoul nd Me mark	မ	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	na Address (Str			ar, City or Town, State	Zin Code)
Mar	ulth au 27 ia r treu		Ann G. Strain/	Wife						Gaithers	
saitimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene.  In an an an an an an an an an an an an an		20a. Method of Disposition			Place of Dispo	sition (Name o	<i>f</i>	Date	20c. Location - City	
Ē	Page nt o		1 ☐ Burial 2 🖾 Cremation `4 ☐ Donation 5 ☐ Other (S		_	cemetery, cres	olitan	Jar	nuary 24, 2006	A.1 1	774 24 4
	oorte		21. Signature of Funeral Service		\			Idress of Facility		uneral Hor	a. Virginia
מ	P P P P P P P P P P P P P P P P P P P	10.0	Month	tool	M006	89 10	East	Deer Park			g, MD 20877
			23a Paril Enter the disease, or shock, or heart failure. List	complications that	caused the de	eath. Do not ent	er the mode of	dying, such as car	diac or respiratory ar	rest,	Approximate Interval Between
4	Pnys <b>icia</b> n <sub>1</sub>	δ.,	Immediate Cause (Final disease or condition			piratory					Onset and Death
	/Medical		resulting in death)	d	o (or as a cons						110010
	Examiner		Sequentially list conditions	b. Chr	onic 0	bstructi	ve Pul	nonary Di	isease		
-	ν ÷;	iner	Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		(or as a cons						
	ecute and -trans	Examin	that initiated events resulting in death) Last	G	nchiol		ar Car	cinoma of	F Right Lu	ng	
0/00	icate be executed physicien and the burial-transit	ai E	,,				cinoma	of Oroph	narwny		
00	phys phys the	dical		d. Dqu	dillous .	ocii oai	CITOMA	or oropi	iai y iix		
X	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	IF FEMALE:	23c. If yes, o	utcome of pred	anancy				22d Date of a	loli nos:
200	atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fi	etal death 3	Ectopic pregna Other (specify			23d. Date of d Month	Day Year
į	the d ny the achec	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk			, (opean)	/			
<u>_</u>	s that ned b	by Pi	Part II. Other significant condition	ns contributing to	death but not r	resulting in the u	nderlying cause	given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
, C	quire an sig uld b								1 <b>½</b> Y	′es 2 □ No 3 □	Probably 4 Unknown
2	aw requir s been si 2 should	ompleted							24a. Was a		autopsy findings available
č	The I	Ho							— autop: perfor 1 ☐ Yes	med? death'	o completion of cause of es 2 No
ומ	aicion: The law certificate has b irector, page 2 s	Be C	25. Was case referred to medical					26. Place of	Death (Check only or	A	2 110
>	nyaic nis ce direc	ToE	examiner? 1 ☐ Yes 2 <del>Q</del> No	Hospital: 1	Inpatient 2	☐ ER/Outpatien	t 3 DOA	Other: 4 Nursin	ng Home 5 🔀 Resid	ence 6 Other (Sp	pecify)
5 =	ng Pt fter t neral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date (Moi	of Injury nth, Day Year)	28b. Time of Injury	28c. l	njury at Work?	28d. Describe h	ow injury occurred	
2	lendi eath. or: A the fu	cati	2 Accident investig	ation			М	☐ Yes 2 ☐ No	, N		
=	or At fter d jiract in by	Certification:	4 Homicide determine	ned 259. Plac	e of Injury - Al ding, etc. <i>(Spe</i>	t home, farm, str <i>icify)</i>	et, factory, offi	Ce	28f. Location (S City or Tow	itreet and Number or i n, State)	Rural Route Number,
י נ	pital ours a aral [		200 Cortifies + Continue	- Dharistan Tari					111		
	To the Hospital or Aftending Physicien: The within 24 hours after death.  To the Funaral Diractor: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifyin (Check only 2 Medical I	Examiner: On the I	le best of my k basis of exami nner stated.	ination and/or inv	occurred at the restigation, in n	e time, date and pl ny opinion, death o	lace, and due to the o occurred at the time, o	ause(s) and manner date and place, and d	as stated. Le to the cause(s)
	o the	Me	29b Sign ture and title of certifier	2	inoi statou.	_	29c. Lic	ense number	2	29d. Date signed (Mo	nth, Day, Year)
	11		Mana	& FSIR	11) er /	MD	D07	285		January 23	
	1> ,		30. Name and address of person v	who completed car	ise of death (II	tem 23a) (Type				<b>-</b>	
			James A. Brown					#300 <sub>17</sub>	nainet	Marvland '	20895
	Sta	te	31. Date filed (Month, Day, Year)	32	Registrar's Sig	mature A	ede 1	# JVU, Ke1	us rugton,	riar A Taila 1	.00/5
	Registra	ar	JAN 30	2006	gue.	Dr M					

			1 - State Registrar			Cert	ificate of l	Death		giene Reg. No.	000	040-	}
	Dhuaisi		1. Decedent's Name (First, Middle, La	st)					2. Date of Dea	ath Day	Year	3. Time of De	ath
	Physici /Medio		Arlene Adams Seme	ler					1	Zé			М
	Examin	er	4a. Facility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death			County of Dea		
			Will was profited	al medical	Cent	e/	If Under 1 Year	SUCY If Under 24 Hrs.	Doto of Sid		Vicon		
	Funeral Director			1 ☐ M 2 🗓 F	(In yrs. last i	Yrs.	Months Days	Hours Min.	8. Date of Birt (Month, Da	y, Year)		rthplace (State or F ou <i>ntry)</i> ¶aryland	oreign
			Usual Residence of Decedent		/-1				MOVEMBE	L II /	, 1 2 0 1	aryrand	
	yland		10a. State 10b. County		10c. City, To	own or Loca	ition					10d. Inside City L	
	Ba-f s	cto	Maryland Wicomic	5	Salish	oury						1 <b>X</b> Yes 2	□No
	라 다 0 28	Dire	10e. Street and Number				10f. Zip Code				zen of What C	ountry?	
	death with the Maryland ms 23e or 28a-f show crimat be ricilited at	Funeral Directo	703 Spring Ave.	Team and			21804			USA			
	ltam Itam	une	11. Marital Status  1 ☐ Never Married 2 ☑ Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ No		13. W	as Decedent of H res, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecity Yes or No- Rican, etc.)		14. Race - Am Black, Wh		
0000	ir, or	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	•	1 (	∐Yes 2. No	Specify:			Specify: Wh	ite	
Ş	72 hours after natural, or Ita		15. Decedent's E	ducation	16	Sa. Decede	nt's Usual Occup	ation			nd of Busines		
7	within 7 ene. then "n	Completed	(Specify only highest grant (0-12)	College (1-4or 5-	+)	life. Do	na or work aone o O NOT use retirea	during most of work f)	ing				
7	filed with Hygiene. Sther the	Con	12			ecret	ary				or's C	ffice	
aua	tai H d oth	Be	17. Father's Name (First, Middle, Last	)				18. Mother's Nam				_	
2	should be nd Mental marked o umatic eve	은	Howard Adams	Turn Brief		01- 14-TF-		Carrie I					
<u> </u>	d 2 sho		19a. Informant's Name/Relationship ( Karen Beauchamp/D	* * * * * * * * * * * * * * * * * * * *		_		and Number or Rur • Salisbu					
ย์	nit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan crament of Heelth and Mental Hygiene. ortants if Item 27 ie marked other then "natural", or Itams 23a or 28a-f show injury or other traumatic event, Ite Medical Exporter man be notified at a		20a. Method of Disposition	24911662	20h Place	of Disnosi	ion (Name of	Ī	Date		cation - City o		
2	ages ant of tt: if li y or c		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Wicor	ntery, crema M1CO	tory or other place Memorial	θ)	\c				
SaitIIIO	permit. Pages 1 end 2 Department of Heelth s Important: if Item 27 is eny injury or other tra		21 Signature of Fun ral Service Lice	•	Park		Name and Addres					Maryland	
ŏ	Depa Impo eny i	<	Doi: 134 11	Jamosa	> CFS	PHO	lloway F	uneral Ho	ome P.A.		la ruzlan	N081C 5	
ı			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. D	o not enter	the mode of dyin	g, such as cardiac	or respiratory ar	rest,	aryran	Approximate Interval Between	en
	Physician		Immediate Cause (Final disease or condition	An.	×1: 6	MIL	howall	_				Onset and Dea	ith
,	/Medical		resulting in death)	Due to (or as a	consequenc	ce of):	1.0	7				- 12	
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	ed sslt	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequenc	ce of):	0					M. T.	ls.
•	xecut and ai-trar	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	ce of):	7 100	<b>~</b>				1 (10-76	///
2	ficate be executed physiclen and s the burial-transit	alE											
	ifficate g phy as the			d									
00/00	5 5 0	edical	•	_ d						-			
700 XO	h ce endi		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome o		ath 3 FT	ctopic programa			2	3d. Date of de	alivery	1
. DOX DO	death ce ne ettendi ad for use		23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No	1⊡Live birth 2 4⊡Pregnant at t	Fetal dea		ctopic pregnancy Other (specify)			2	3d. Date of de Month	alivery Day Yea	ır
T.O. DOX 007	et the death ce I by the ettendi stached for use		23b. Was decedent pregnant in the past 12 months? 1  Yes 2  oo 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal dea time of death	5 🗆 (	Other (specify)				Month	Day Yea	
S, P.O. BOX 607	res thet the death ce signed by the ettendi be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ■ No	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal dea time of death	5 🗆 (	Other (specify)			obacco u	Month se contribute	Day Yea	th?
ords, P.O. Box 6670	requires thet the death ce seen signed by the ettendi hould be detached for use	by Physician/M	23b. Was decedent pregnant in the past 12 months? 1  Yes 2  oo 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal dea time of death	5 🗆 (	Other (specify)				Month se contribute	Day Yea	th?
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			1 - For State Registrar		State of Ma	arylan		artment d rtificate				ene ()	06	04042	)
	Di vi		1. Decedent's Name (First,	Middle, La	st)						2. Date of Death			3. Time of Death	_
	Physic /Medi		DAVID	EDWAF	D SHEREN						Month C	Day 18	Year	0740 M	í
	Examir		4a. Facility Name (If not ins.	itution, giv	e street and number)			4b. City, Tov	vn, or Locat	tion of Death		4c. Coun	ty of Death		
			Peninsula I	egion	ral medic	al C	enter	Say	lisbu	114		Wie	Conic	0	
	Funeral Director	ľ	5. Social Security Number 306-56-3979	6. S	ex 7. Ag	6 (in yrs. ) 52	last birthday) Yrs.	If Under 1 Y Months Da	ays Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day,	(ear)	9. Birthp	lace (State or Foreign try)	7
			Usual Residence of Decede	nt							05-28-19	153	Indi	ana	_
	urylan show	_	10a. State 10b. C	•		10c. City	y. Town or Lo	ocation					1	0d. Inside City Limits	
	8a-f	cto		ssex		La	urel							1 ☐ Yes 2 🛣 No	
	with th	Dire	10e. Street and Number					10f. Zip Co			100		Whal Coun	itry?	
	eath	erai	9890 Lobloll	y Ave	12. Was Decedent	Cups in 111	C   10	199		0::0:0		US			
2-003b	in 72 hours after death with the Maryland "natural", or iteme 23a or 28a-1 show ledical Expriner must be notified at	by Funeral Director	1 □ Never Married 2₹		Amed Forces?  1 2 Yes 2 1 Yes, Give 1 Year or Dates:			was Decedent If Yes, specify ( 1 ☐ Yes 2X			cify Yes or No- Rican, etc.)		ace - Americ ack, White, ify: Wh		
ခု ဂ	2 8 3	eted	15. Dec	edent's Ed	ducation de completed)		16a. Dece	dent's Usual Od kind of work do	cupation	mant of wardin	16	Sb. Kind of	Business/Ind		_
17.17	iene.	Completed	Elementary/Secondary (0	12)	College (1-4or 5	i+)	Sale	DO NOT use re	atired)	most or workin		.quor	Distr	ibutor	
	lid be fit fental H rked oth	Be	17. Father's Name (First, Mi								(First, Middle, Ma	iden Suma	me)		
Z	2 should to and Ment is marked aumatic e	ပ	Francis She		5				- 1	orma Na					_
Ma,	5 = 2 =		Donna Sheren				9890	ng Address (Str	eet and Nu Ly Ave	mber or Rural e, Laur	Route Number, C el, DE l	ity or Town .9956	n, State, Zip	Code)	
o e	jes 1 a of Hea if item or othe		20a. Method of Disposition 14∑ Burial 2 ☐ Crema	tion 3 🗆	Removal from State	20b. PI	ace of Dispo	sition (Name o	f pjące)	Da	ate 20	c. Location	- City or To	wn, State	_
	mit. Peges I pertment of H portant: If Ite y Injury or ot		4 □Donation 5 □Oth	er (Specify	')			Cemeter		02/02/	'06 Mi	llsbo	ro, D	E	
ng D	Departing of the portion of the port	-	21. Signature of Euneral Se	Cran	ston S		22	Name and Ad Cransto P O Box	on Fur Spirate 1967.	neral H Seafo	ome ord, DE l	9973			
			23a. Part1. Enter the disease shock, or heart failure.	e, or comp	olications that caused	the death	. Do not ent	er the mode of	dying, such	as cardiac or	respiratory arres			Approximate Interval Between	_
y I	Physician		Immediate Cause (Final disease or condition resulting in death)	8 00	a. Musc	ard i	al I1	farct	lon					Onset and Death	
*	/Medical Examiner		1630king in Geath)		Due to for as a	a consequ									_
		er	Sequentially list conditions, if any, leading to immediate		b. Due to (or as a	a constituti	ence off								_
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	~	(		2.,,								
5	an an rial-tr	Exa	resulting in death) Last		Due to (or as a	consequ	ence of):						-		-
0/0	ficate be executed physician and s the burial-transit	edicai			d										
	ertifica ling pt e as t		IF FEMALE:	-											Ī
	ettend for us	ician/M	23b. Was decedent pregnar in the past 12 months?	t	23c. If yes, outcome of 1 Live birth	2 Fetal	death 3	Ectopic pregna				- 1	ate of deliver	y Day Year	
į	y the d	Physic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4☐Pregnant at t 9☐Unknown	time of dea	ath 5∟	Other (specify	)				J	ouy rour	
	Attending Physician: The law requires that the death certif death, at death, estern Ailer this certificete has been signed by the ettending by the funeral director, page 2 should be deteched for use a	by Pr	Part II. Other significant con	ditions co	ontributing to death bu	it not resul	Iting in the ur	iderlying cause	given in Pa	art I.	23e. Did tobac	co use con	tribute to the	cause of death?	
3	w require been sig should b										Yes	2 🗆 No	3 🗌 Proba	bly 4 □Unknown	
3	e law requ has been je 2 shoul	Completed									24a. Was an	24b.	Were autop	sy findings available	-
	certificete h	Com									autopsy performed	3/	prior to com death? 1  Yes		
	iclan: Th certificete rector, pag	Be (	25. Was case referred to me examiner?	-					26. Pl	ace of Death	Check only one	(NO			
5 ;	Physical this call direct	P.	1 Yes 2 No		Hospital: 1 Inpatier						e 5 Residenc				
5	ding h. After funer	tion	27. Manner of Death 1 Natural 5 □ Pe	nding estigation	28a. Date of Injury (Month, Day	Year)	28b. Time of Injury	V	york?		ld. Describe how	injury occur	red		
2	Atten deat octor: by the	fica	3 ☐ Suicide 6 ☐ Co	uld not be termined	28e. Place of Injur	rv - At hon	ne farm stre		Yes 2		If. Location (Stree	at and Numi	har or Rural	Pauto Number	_
	spital or Atten ours after deat teral Director: filled in by the	Certification:	4  Homicide de	terrimed	building, etc.	(Specify)		ot, tuotory, one			City or Town, S	itate)	on or Aurai	noute Number,	
:	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier Cort 2 Med	ifying Phy ical Exam	sician: To the best of iner. On the basis of and manner stat	examinatio	ledge, death on and/or inv	occurred at the estigation, in m	time, date y opinion, c	and place, an death occurred	d due to the caus dat the time, date	e(s) and mand place,	anner as sta and due to	ted. the cause(s)	
,	To To To To To To To To To To To To To T	Ž	29b. Signature and title of ce	rtifier				29c. Lice	ense numbe	er	29d.	Date signe	d (Month, D	lay, Year)	-
	100/		Chit					200	053.	394		1/28	106		
4	218		30. Name and address of per	son who c	ompleted cause of de-	ath (Item 2	23a) (Type, F	Print)		/	MD a				
1	C.		31. Date filed (Month, Day, Y	ear)	32. R. strai	de Signatur	0//	St. S	alist	bury	MD a	1801			
	Stat Registra		*	3 0 2		(See )	KA	ments 1							

)			1 - For State Registrar	State of I	Maryland / De <i>C</i>	partment o e <i>rtificate</i> d		nd Mental Hy	giene	06 04043	3
	Physici /Medic		Decedent's Name (First, Middle, L Eric Charles S	•				2. Date of De Month JANUARY	eath Day	3. Time of Death 2:55A.	М
	Examir		4a. Facility Name (If not institution, g			ANNA	vn, or Location of POLIS	Death	4c. County		
	Funeral Director		5. Social Security Number 6. 557–98–5478 Usual Residence of Decedent	Sex 7.	Age (In yrs. last birthda 51 Yrs.	Months Da	ear If Under 2 ays Hours	Min. 8. Date of Bir (Month, Date 2	ay, Year)	9. Birthplace (State or Forei Country) California	gn
	e Maryland a-f ehow	ctor	Maryland 10b. County  Maryland Anne A	Arundel	10c. City, Town or		Annapol:	is		10d. Inside City Limit	
	ath with the 23a or 28	ral Director	10e. Street and Number 2004 Harbour Gat	es Drive,	#88	10f. Zip Coo	<sup>de</sup> 214	401	10g. Citizen of V	Vhat Country? S.A.	
900	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. If them 27 ie marked other than "naturel", or fleme 23a or 28a-f show other traumatic event, the Medical Examination must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Worced	12. Was Decede Armed Force 1	s?	3. Was Decedent If Yes, specify (		in? (Specify Yes or No Puerto Rican, etc.)	14. Race Blace Specify	e - American Indian, k, White, etc. :: White	
Maryland 21215-0036	d within 72 h piene. r then "natu	Completed	15. Decedent's E (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-40	(Gi	cedent's Usual Oc ve kind of work do DO NOT use re Manage	one during most o etired)	of working		ear Power	
yland ;	should be filed und Mental Hygie	To Be C	17. Father's Name (First, Middle, Las William Sopkin		9			's Name (First, Middle nita Handle		θ)	
, Mar	1 and 2 sho Health and em 27 le ma		19a. Informant's Name/Relationship Michael Sopkin/		2400	Spruce	Court (	or Rural Route Numb Colleyville	er, City or Town, e, Texas	State, Zip Code) 76034	
altimore,	permit. Pages 1 and Department of Health Important: If Item 27 eny injury or other t	4	20a. Method of Disposition  1 ☐ Burial 2X☐Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Spec	ify)	Baltimor	e Crematory or other	ory 1/	Date /28/2006	Baltimo	city or Town, State re, Maryland	
Ba	Dermi Depar Impor eny in		21. Signature of Futheral Service Lice	, di	le	147 Duke	of Glou		, Annap	neral Home olis, MD 2140	1
	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Due to (or a	TVG IWG us a consequence of):	mer the mode of	dying, such as ca	ardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
8/60,	cate be executed physician and the burial-transit	dicai Examiner	if any, leading to immediate cause. Enrer Underfung Cause (Disease or injury that initiated events resulting in death) Last	c	is a consequence of):						
CO. BOX 6	I the death certificate the attanding parties as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death 3	☐Ectopic pregna☐ Other (specify			23d. Date Mor	e of delivery th Day Year	
Records, P	w requires that been signed to should be det		Part II. Other significant conditions	contributing to death	but not resulting in the	underlying cause	given in Part I.	23e. Did to	. /	ibute to the cause of death? 3  Probably 4 Unknow	n
Hec	The law ate has b page 2 si	Completed							rmed? d	Vere autopsy findings available for to completion of cause of eath?  ☐ Yes 2☐ No	ө
VII		o Be	25. Was case referred to medical examiner?	Hospital:			Ott	f Death   Check only o			
5	g Phys ar this eral di	- 1	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of In		SIL SU DOA	4 114015		dence 6 X Othe now injury occurre	or (Specify) SCENE	
5	ath.	atio	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation			-∆ M 1	njury at Work? □ Yes 2 ☑ No		ar its		
DIVISION	To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director, After this completely filled in by the funeral di	Certification:	3 Sussicide 6 □ Could not be determined	building,	njury - At home, farm, setc. (Specify)	treet, factory, offic	ce	28f. Location (5 City or Tox	Street and Numbe vn, State)	or or Rural Route Number,	-
	Hosp 24 hou Funer itely fill	edicai	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Execution	miner: On the basis	t of my knowledge, dea of examination and/or i	ath occurred at the	e time, date and p ny opinion, death	place, and due to the	nauco(a) and man	nor no stated	
:	ro the within ? To the comple	-	29b. Signature and title of certifier	and manner s	iaied.		ense number			(Month, Day, Year)	
	, ,		30. Name and address of person who	completed cause of	(WV) death (Item 23a) (Type		C.M.E.		IANUARY 2		
			MARYSMITS	D. KORE	li		NN STREE	T BALTIMOR	E, MARYI	AND 21201	
	Stat Registra	۳	31. Date filed (Month, Day, Year)  JAN 2 5 7		trar's Signature	hand .					

			1- State of M	aryland			t of H	lealth a	and M	-		006	04044
	Physic	ian	1. Decedent's Name (First, Middle, Last)							2. Date of Dea		Year	3. Time of Death
	/Medi	ical	WILLIAM J. SCHAFER, JR.  4a. Facility Name (If not institution, give street and number)			45 03	<b>T</b>		10 11	JANUARY	_		6:35 P м
1	Exami	ner				·		Location				ounty of Death	
	Funeral				ast birthday)	If Under	1 Year	E HAI	24 Hrs.	8. Date of Birth	ST		S place (State or Foreign
	Director		163-22-6611 ¹ <del>\</del> x <sup>M</sup> <sup>2□ F</sup>	76	5 Yrs.	Months	Days	Hours	Min.	8. Date of Birth Month, Day NOV 2,	1927	PEK	NSYLVANIA
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation							10d Inside City Limite
	the Marylan 28e-f show	ō	MD CHARLES	WALI									10d. Inside City Limits 1 ☐ Yes 2 No
	r 28e	irec	10e. Street and Number	1 111111	JORI	10f. Zip	Code			1	0g. Citize	on of What Cou	ntry?
	th with 236 o	Funeral Director	6063C THOROUGHBRED COURT			2	0603	,			-	. S. A.	•
	tems er m	Juer	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S	3. 13. \	Vas Deced	lent of Hi	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	14	I. Race - Ameri Black, White,	
36	', or It	by Fu	1 ☐ Never Married			I□Yes 2		Specify:	, , , , , , , , , , , , , , , , , , , ,	, , , , , ,	s		
9	be filed within 72 hours after death with the Maryland stal Hygiene.  do other then "netural", or Items 23e or 28e-1 show event, the Madical Exeminer must be inclined at	edt	15. Decedent's Education		16a. Deced	lent's Usua	1 Occupa	ation				WIT d of Business/In	TTE
215	hin 7. e. en "n	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or secondary (1-4or secondar	5+)	(Give	kind of wor OO NOT us	k done d	lurina most	t of workir	ng	TOD. TUITO	01 000111000111	addity
21	filed with Hygiene. Ither ther	Completed	12		SUPER	VISOR					IRO	N WORKS	
and	e d fa	To Be	17. Father's Name (First, Middle, Last) WILLIAM J. SCHAFER							(First, Middle, M NE SKOL		umame)	
2	2 should be filed within and Mental Hygiene. Is marked other then sumatic event, Ing M	P	19a. Informant's Name/Relationship (Type, Print)		10b Mailin	a Address	(Ctmat a					r	
¥a	2 2 2 2		ETHEL L. SCHAFER / WIFE		6063	C THO	ROUG	HBRED	COU	ROute Number RT WALD	ORF,	MD 206	03
ore,	of Health of Health fitem 27 r other tr		20a. Method of Disposition	20b. Pla	ace of Dispo: metery, cren	sition (Nam	ne of	e)	Da	ate	20c. Loca	tion - City or To	own, State
imo			<b>XX</b> Burial 2 □ Cremation 3 □ Removal from State  '4 □ Donation 5 □ Other (Specify)	MD	VETER.	ANS C	EMET	ĔRY¦ F	EB.2	,2006	CHEL'	TENHAM,	MARYLAND
Ealtimore, Maryland 21215-0036	permit. Pag Dapartment In portent: I er y injury o		21. Signature of Funeral Service Licensee	MOC	)641 <sub>30</sub>	Name and	d Address	s of Facility	BRIN CH R	SFIELD-	ECHO: LOTT	LS FUNL	.HME.,P.A. MD 20622
			23a. Part1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each li	10.	Do not ente	er the mode	of dying	, such as	cardiac or	respiratory arre	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	anc	ed	Alz	he	ime	V 5	s de	ME	ntia.	Onset and Death
	Examiner		Due to (or as	a conseque	ence of):							-	J- / 1
		ē	Sequentially list conditions, if my, leading to furnishing cause. Enter Underlying Cause (Disease or injury	а полведие	erine of jt								
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
,00	ate be executed hysician and the burial-transit		resulting in death) Last Due to (or as	a conseque	ence of):								
8760,	icate be executed physician and s the burial-transit	Physician/Medical	d	_	_								
9 x	death certifica e attending pl d for use as t	/Me	IF FEMALE: 23c. If yes, outcome	of pregnant	cv						T		
Вох	atter d for u	clan	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 4 Pregnant at	2 Fetal o	death 3	Ectopic pre Other (spe					230	d. Date of delive Month	Day Year
0	that the di ed by the detached	hys	9 Unknown 9 Unknown				,,,						
s, P	the taw requires that the ste has been signed by th page 2 should be detache	by P	Part II. Other significant conditions contributing to death be	ut not result	ting in the un	derlying ca	use givei	n in Part I.		23e. Did tob	acco use	contribute to th	e cause of death?
ord	nequir s usu	ted	Benign Prostatic	nyp	er M	oph	4			1 ☐ Ye	s 2 🗆 l	No 3□Prob	ably 4 Junknown
Sec.	e taw has b je 2 sł	Completed				_				24a. Was ar autopsy	,	prior to car	osy findings available inpletion of cause of
										perform 1 Yes 2	No No	death? 1 ☐ Yes	2 No
<b>5</b>	rnysicien: this certifica ral director,	o Be	25. Was case referred to medical examiner?  1  Yes 2  No Hospital: 1 Inpatie				Othor			(Check only one			
10	g rny er this eral d	$\vdash$	27. Manner of Death 28a. Date of Injur	y 2	R/Outpatient 8b. Time of		c. Injury : Work?	A INUIS		e 5 Resider			')
io	ath. or; Aft	atio	1 ≝Natural 5 □ Pending (Month, Day 2 □ Accident investigation	rear)	Injury	M		? es 2 🗍 N	lo				
Division	after death. Director; After	Certification:	3 Suicide 6 Could not be determined 28e. Place of triple building, etc.	ry - At hom . (Specify)	e, farm, stre	et, factory,	office		28	Bf. Location (Str. City or Town,	eet and N	lumber or Rura	Route Number,
Δ ;	hours at hours at unerel D												
	or the nospine or Attending Prysicient, within 54 hours after death.  To the Fuherel Director; After this certific completely filled in by the funeral director,	Medical	29a. Certifier (Check only only) (Check onl	examinatio	edge, death in and/or invi	estigation, i	n my opi	nion, death	place, ar	d at the time, da	te and pla	ace, and due to	the cause(s)
,	T wit	-	29b. Signature and title of certifier				License		7	29	d. Date s	igned (Month, I	Day, Year)
ę		-	30 Name and address of passed with applications	ath /lic-	12a) /T.:: -			09 á			1/5	30/0	6
N	3511		30. Name and address of person who completed cause of de	uto 2	(Type, P	55	Ri	DOP	TV	edvick		MAS	20678
	Sta		31. Date filed (Month, Day, Year) 32. Registra	_	ге	,	1 //	,,,,,,	- [ * 6	JAVI CK		100	9 - 10
	Registr	ar	JAN 3 1 2006 See	w L	" A	rede							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 01.045 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Vear **Physician** John Donald Slick February 06 2006 0505 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Carroll Westminster If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Yrs 76 25 Director 213-24-8363 1929 October MD Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 ie markad other then "natural", or iteme 23a or 28a-1 ehow eny injury or other traumatic event. It a Medical Examinar must be notified at Carroll Gamber 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3921 Gamber Road 21048 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? ★□ Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Truck Driver Hess Oil Co 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles H. Slick Annie Angel ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1001 Scarlet Oak Ct., 3A , Hampstead, MD Nancy Slick/daughter 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Providence Cemetery 2/10/2006 4 ☐ Donation 5 ☐ Other (Specify) Gamber, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Faculity
Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part/. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Brain damage NXIC Physician /Medical Examiner latera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transit Due to (or as a consequence of): Box 68760, the attending physicien Physician/Medical use es the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. sete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, δ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed certificete 1 Yes 2 No Division of Vital To the Hospital or Attending Physician: within 24 hours effer death.

To the Funeral Director: After this certifice uneral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ٩ 1 Inpatient 1 ☐ Yes 2 ER/Outpatient 3 DOA 27. Manner Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 Yes 2 No 2 Accident completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28t. Location (Street and Number or Rural Route Number. City or Town, State) 4 \( \text{Homicide} \) 1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 139402 MM

10 State Registrar address of person

ad 31. Date filed (Month,

DHMH 17 Rev 1/2001

447,

East Main St Westwester

ause of death (Item 23a) (Type, Print)

egistrar's Signature

		1 - For State Registrar	State of Mary	land / Dep		nt of H	ealth a	ind Me	Re	ene ()	6 0	14046	
Physic /Med	ical	Della Bernice Sl     As a Facility Name (If not institution, given the property of the pr	aughter		Ab Cibe	Tours or	Location of	1	2. Date of Death Month February	Day <b>7</b> 3	Year 2006	3. Time of Deal	.h M
Exam		The Johns Hopkins 5. Social Security Number 6. S	Hospital	yrs. last birthday 84 Yrs.	Ва	ltimo	re Ci	ty 24 Hrs. 8	Date of Birth		9. Birthp	lace (State or For	eign
Directo		Usual Residence of Decedent 10a. State 10b. County	100	. City, Town or L				Ma	ay 31,	1921	Mary	0d. Inside City Lin	
with the Maryland a or 28e-f ehow	Funeral Directo	Maryland Carro  10e. Street and Number  8 Charles St.	011	Westmin	10f. Zij	p Code	,		10	g. Citizen of		1 Xves 2 utry?	No
5-0036 72 hours after death with the Maryland neturel, or items 23a or 28a-f show dieal Examiner must be notified at	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	in U.S. 13.			spanic Orig n, Mexican,	in? (Speci Puerto Ri	fy Yes or No- can, etc.)		ice - Americ ack, White, e	etc.	
Maryland 21215-0036 nd 2 should be filed within 72 hours aft the and Mental Hygiene. 27 Is marked other then "neturel", or reteumatic event, the Medical Exam	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	dent's Usu kind of wo DO NOT u	ork done d ise retired	ation luring most	of working	1	6b. Kind of E		ag <b>i</b> ng	
aryland should be file and Mental Hy marked oth umatic event	To Be	17. Father's Name (First, Middle, Last, Charles E. Brown 19a. Informant's Name/Relationship (		19h Mail	ng Address	Street s	Ro	xie l	First, Middle, M.  Ouise   Route Number,	Кеу		Codel	
9 t a a a a	1 2	Frederick W. Slau 20a. Method of Disposition	ghter (Son)	4636  b. Place of Displacemetery, cre	Turke	eyfoc	t Rd.		estmins		d. 21	158	
Baltimore, permit. Pages 1 a Department of Healmportment: If them any njury or other once.		1X Burial 2 Cremation 3 4 Donation 5 Other (Specifical Signature of Funeral Service/Licer	s) S	t. James	Ceme 2. Name ar	etery	s of Facility		006 N zler Fur on Bridg		Home		
The law requires that the death certificate be executed as been signed by the attending physicien and page 2 should be detached for use as the burial-transit	edicai Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teaching to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	plications that caused the cone cause on each line.  Right Ve a.  Due to (or as a con Renal Fa b.  C. Adult Re Due to (or as a con Preumoni d.	ntricula sequence of): ilure sequence of). Spirator sequence of):	er the mod	ilure	g, such as c	ardiac or r	espiratory arres			Approximate Interval Between Opset and Death I day  1 day  8 days  21 days	
P.O. Box 68 nat the death certificated by the attending ptetached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	⊒Ectopic pi ⊒ Other (sp						ate of deliver	ry Day Year	
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of Vital Physician: T this certificate ral director, pa	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 (**) Anpatient 2	2 □ EB/Outnation	at 3□ DC	Othe	c		Check only one 5 Residen		has (Cassite	1	
Division of 1 or Attending Physafter death. Director: After this in by the funeral di		27. Manner of Death  1 XX Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year			28c. Injury Work	- L 14013	280	d. Describe how			)	
Division of Vita vithe Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	i Certification:	3 Suicide 6 Could not be determined	building, etc. (Sp	ecify)					. Location (Stre City or Town,	State)			
• Hos • Fun letely f	Medical	(Check only one)	ysician: To the best of my niner: On the basis of exam and manner stated.	nination and/or in	vestigation	, in my op	e, date and inion, death	plade, and occurred	I due to the cau at the time, date	e and place,	anner as sta and due to	ited. the cause(s)	
To the within To the compl	Me	29b. Signature and title of certifier	Medie		7	RES-				d. Date signe ebrua	*		
3 3	ate	George Ho, The Jo		Hospital	, 600	Nor	th Wo	lfe S	St. Balt	imore	, MD :	21287	

			1 - For State Registrar	State of M	laryland / Dep <i>Ce</i>	ertificate of			giene	)6 0	4047
	Physic /Medi		1. Decedent's Name (First, Middle, Lewis Ra		Stevens			2. Date of Dea	ath	2006	3. Time of Death 8:10P M
	Exami		4a. Facility Name (If not institution,		)	4b. City, Town, o	r Location of Deat		4c. County		
1			Glade Valley Nur	sing & Reh	ab. Center	Walke	ersville		Fr	rederio	ck
,	Funeral Director		182-14-6194	5. Sex 7. A 1 M 2 □ F	ge (In yrs. last birthday 86 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day Jan. 2	1,1920	9. Birthplace Country Penns	ylvania
	and **	1	Usuaf Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				104	. Inside City Limits
	88-f sho	ctor	MD Freder	ick	,	bana				100	1 Yes 2 XNo
	th with th	Funeral Director	10e. Street and Number 9723 Royal Cr	est Circle		10f. Zip Code	1704		10g. Citizen of V		7?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or iteme 23a or 28a-f show shi njury or other traumatic event, the Medical Examinar must be notified at ance.	þ	11. Marital Status  1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Was Decedent Armed Forces 1 Q Yes 2 If Yes, Give Year or Dates:	No	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Rac Blac Specify	e - American ck, White, etc	).
5-0	72 hg	eted	15. Decedent's (Specify only highest	Education grade completed)	16a. Dece	edent's Usual Occup	ation	kina	16b. Kind of Bu	usiness/Indus	stry
21215-0036	od within giene. er then "	Completed	Elementary/Secondary (0-12)	College (1-4or	life.	er/shippe	1)	g	Steel	tube m	nfg.
Maryland	uld be file fental Hy rked oth	To Be (	17. Father's Name (First, Middle, La Walter G. Stev					ne (First, Middle, McDermot		ne)	
Mary	nd 2 should lith and Men 27 le marke r traumatic		19a. Informant's Name/Relationship Marla Grenier -		19b. Mail 97	ing Address (Street )	and Number or Ru Crest Ci	ral Route Number	r, City or Town, bana, M	State, Zip Co	ode) ) 4
Baltimore,	ages 1 a ant of Hea it: If item y or othe		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe			osition (Name of matory or other place		Date	20c. Location -	,	
Baltir	permit. P Departme Importan eny injur		21. Signature of Funeral Service this		2	2. Name and Addres	ss of Facility Ha	rtzler F		Home	, PA
	40200		23a. Part1. Enter the disease, or co	mofications that cause		10 Church					
81	Physician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	a	ine.	hean	rael		est,	ln'	oproximate terval Between inset and Death
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,	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
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9 x	leath certific attending p	/Me	fF FEMALE:	23c. If yes, outcome	of pregnancy				00 1 0 1	-4.4.6	
P.O. Box	The law requires that the death certificate be executed tie hes been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 menths?  1  Yes 2 No 9  Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Dati Mor	e of delivery nth Da	y Year
	uires that signed to id be deta		Part II. Other significant condition:	contributing to death t	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contr		ause of death?
000	w requir been s should	iete	( A=0	! = 570	nosis			24a. Was a	24b V	Mara autonou	findings available
Vital Records,		Completed by	V	- 079	V/ V / 3			autops perfori	med3 d	prior to complete th?	findings available etion of cause of
Ž.	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:	1000	Oth		th (Check only on			
o		- To	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 ☐ Inpati			4 Nursing H	ome 5 ☐ Reside			
O	ding th. : After funer	ţ	1 Natural 5 Pending 2 Accident investigat	(Month, Da	ly Year) Injury	Work	rat res 2 □ No	28d. Describe ho	w injury occurr	ea	
Division	il or Attending after death. Director: After d in by the fune	Certification:	3 Suicide 6 Could not 4 Homicide determine	be 28e. Place of In	jury - At home, farm, str c. (Specify)			28f. Location (St City or Town	treet and Number, State)	er or Rural Ro	oute Number,
_	d hours unerel	ledical Co	29a. Certifier 1 Cartifying (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of	it examination and/or in	h occurred at the tim vestigation, in my op	e, date and place, pinion, death occur	and due to the cared at the time, d	ause(s) and mar ate and place, a	nner as state	d. e cause(s)
	To the P within 2-	Mec	29b. Signature and title of certifier	and manner st	ated.	29c. License			9d. Date signed		
)	101)		A L	Shah G	n r v =	Ds			_		
•	Cen	-	30. Name and address of person wh	o completed cause of c	teath (Item 23a) (Type.	)		Ver Of	1100	00	
	.5		SE T	mas	Than sr	m Dr	FVE	Ven on	c m	21	702
1	Sta		31. Date filed (Month, Day, Year)	32 Registr	are Signature			3.07	1		/
	Registr	ar.	FEB 0 6	ZUUB JOG	we to	gosta					

		-	For State Registrar		State o	f Marylar		artmen rtificat					Reg. No	11115	04	048	8_
			1. Decedent's Name	(First, Middle, La	ast)							2. Date of De Month	ath Da	v Year		ime of Dea	.th
	Physicia /Medic	al	LIND		Υ.		THOMAS					January		, 2006		51A	М
	Examin		4a. Facility Name (If I			nber)				Location	of Death		4c	. County of De			
		•	Civista						Plata		0411			Charle			
	Funeral		5. Social Security Nu		Sex 1 □ M 2 <del>□</del> F	7. Age (In yrs. 58	. last birthday) Yrs.	If Under Months		If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9. B	irthplace (S Country)	State or For	reign
	Director	-	577-62-87 Usual Residence of D	00	_ X		113.					AUGUST	_14_	1947 MA	KY LAN	ID	
	and and			10b. County		10c. Ci	ity, Town or Lo	ocation							10d. Ins	ide City Li	mits
	Maryl f sho	ō	MD	CHARLE	S	Н	IUGHESV	ILLE							1 0	XiYes 2 □	] No
	the 28a	Director	10e. Street and Numi					10f. Zip	Code				10g. Ci	tizen of What C	Country?		
	ath with the Marylar 23s or 28s-f show		7225 BRA	NSON FAR	RM PLACE				2063	37			U.S	S.A.			
	death	Funeral	11. Marital Status			edent Ever in U	J.S. 13.	Was Dece	dent of Hi	ispanic Or	rigin? (Spe	ecify Yes or No Rican, etc.)		14. Race - An Black, Wh		ian,	
9	after dea	Fu	1 Never Marrie	d 2 Married	1 ☐ Yes	2 X No	- 1	1 Yes				r modrių Otorij			BLACK		
33	iral',	d by	3 X Widowed 4		Year or D	ates:											
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Itams 23a or 28a-f show ant, Its Medical Examilination at the multified at	Completed	(Specif	15. Decedent's E fy only highest g	Education rade completed)		(Give	dent's Usu kind of wo DO NOT u	rk done d	during mos	st of worki	ng	16b. K	(ind of Busines	s/industry		
121	within ne.	dm	Elementary/Secon-	dary (0-12)	College (1	I-4or 5+)	NUR		30 100100	,			1	PRIVATE			
2	Hygie Hygie ther int, II		17. Father's Name (F	First, Middle, Las	it)		HOR	<u>, , , , , , , , , , , , , , , , , , , </u>		18. Moth	er's Name	(First, Middle					
THOMAS Maryland	0 = 0 =	) Be		PROCTO						MILD	RED	PROCTO	R				
THOMAS Marylan	should be nd Mental markad c	은	19a. informant's Nar	me/Relationship	(Type, Print)		19b. Maili	ng Address	s (Street a	and Numb	er or Rura	al Route Numb	er, City	or Town, State	Zip Code,	)	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic as		JAMAINE	THOMAS	/SON		7225	BRAN	SON 1	FARM	PL.	HUGHESV	/ILLI	E, MARY	LAND	20637	7
ē,	s 1 a of Hei item othe		20a. Method of Dispo				Place of Disponentery, cre	osition (Na	me of other plac	ю)		Date	20c. L	ocation - City of	or Town, Si	ate	
LINDA Baltimore,	Pages nent of int: If it iry or o		1 ≅ Burial 2 ∟ `4 □ Donation		□Removal from eify)	HA	ARMONY	CEME	ΓERY	1	1/27	/06	LANI	OOVER,M	ARYLA	ND	
alti	permit. Departn Importe any inju		21. Signature of Fue	ofal Service Lice	ensee			2. Name a						FUNER.			
<u>m</u>	9 G E E G			TOLL										MARYLA	1	20785	
			23a. Part1. Enter the shock, or heart	e disease, or con t failure. List onl	mplications that on y one cause on e	aused the dea	ath. Do not en		1)	11			arrest,		Interv	oximate val Betweer it and Deat	n
	Physician		Immediate Cause (F disease or condition		a	Se	ptic	5	Ko C	14					Onse	t and boat	
	/Medical Examiner		resulting in death)	- (	Due to	(or as a cons	quence of):	2		R.	\ 0	l					
	Examiner	_	Sequentially list con	ditions.	b	/	450	emi	L	150	00 2				-		
	pe isi	Jue	Sequentially list con if any, leading to immoduse. Enter Under Cause (Disease or in	mediate lying neury	Due to	(or as a conse	duence on.										
	ate be executed hysician and the buriat-transit	Examiner	that initiated events resulting in death) La		c	(or as a conse	equence of):										
760,	siciar burià	calE		•	d												
687	fficate g phy as the																
ŏ	leath certifical attending phy I for use as th	Z/M	fF FEMALE: 23b. Was decedent	pregnant	23c. If yes, ou	tcome of pregr		⊒Ectopic p	reanancu	,				23d. Date of c			
m.	death e atte	icia	in the past 12 r 1 □ Yes 2 □			nant at time of		Other (s						Month	Day	Year	
0.	that the death led by the atter detached for u	Physician/Med	9 🗆 Unknown	V					-					-/		- 6 - 6 11	. 0
Division of Vital Records, P.O. Box	uires tha signed I d be det	by F	Part If. Other signific	cant conditions	contributing to d	leath but not re	sulting in the	1	he te	en in Part	20071	te. 1		use contribute	to the cau Probably		
ord	w requir been s	ted	0/40	1,100 1	Coparo	1 101001	1	VCA	pe/e	<del>~ ' / '</del>	/			-14			
e	e law l has b	Completed										24a. Was	DSV	24b. Were prior to death	autopsy fir o completio	idings avai	lable a of
=	ysician: The l is certificate ha director, page	Cor		/		/						1 ☐ Yes	ormed?	o 1 □ Y	es 210 N	10	
Vita	ilcian: Th certificate rector, pag	Be	25. Was case refere		Hospital: \	/			O. Oth			h (Check only					
of	Phys this al dir	To.	1 yes 2V/1		נשור		28b. Time		GA	4 _ IV		me 5 ☐ Res 28d. Describe		6 Other (Sp	oecity)		
no	ding h. After fune	tlon	1 Natural	5 Pending investigat		of fnjury oth, Day Year)	Injury	М	28c. fnjur Wor 1 □	k? Yes 2□							
S	Atten deat ctor: y the	fica	2 Accident 3 Suicide	6 Could not	be 28e. Place	of fniury - At	home, farm, s	treet, facto	ry, office					nd Number or	Rural Rout	e Number,	
<u>5</u>	al or / after d in b	Certification:	4  Homicide		build	ling, etc. (Spec	city)					City or To	own, Stat	(0)			
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier (Check only	1 Certifying I	Physician: To the aminer: On the b	e best of my kr	nowledge, dea nation and/or i	th occurred	at the tir	ne, date a pinion, de	ind place, eath occur	and due to the	cause(s	s) and manner nd place, and d	as stated. ue to the c	ause(s)	
	the latin 24 the latin the latin mplet	Medical	one) 29b. Signature and		and man	ner stated		/		e number				ate signed (Mp			
	F × F 8		Loo. Signature and	V	11.8	Cho	·~/		D-37				11	18/	200	1	
	2 /10		30. Name and addre	of narean wh	o completed car	se of death /ltr	em 23a) (Tuna	. Print)		4, 1			. /			0	
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	Regist	rar	JAN	2 7 200	IF ACC	ما ريان	17										

			ite of Marylan	d / Depa	artment of Healt rtificate of Dea	h and Me	ental Hygi	•	04049
Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, Last)  SAMUEL  4a. Facility Name (If not institution, give street WASHINGTON ADVENT			4b. City, Town, or Locati	ion ol Death	2. Date of Death Month JANUARY	23 2006  4c. County of Death MONTGOMERY	3. Time of Death 3:49 P M
Funeral Director		5. Social Security Number 6. Sex 12 17 14 5845 6. Sex 12 M 2 Usuel Residence of Decedent 10a. State 10b. County	84	Yrs.  Y. Town or Lo	Months Days Hou	irs Min.	3. Date of Birth (Month, Day, ECEMBER	25 MARY	place (State or Foreign LAND
with the Maryla a or 28a-f ehov	Director	MD PRINCE GEORG	EE'S B	OWIE	10f. Zip Code 20715		10	g. Citizen of What Cour	1X Yes 2 ☐ No
13-UU.30 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show ideal Examinar trival be inclified at	by Funeral	1 Never Married 2 Married 1	as Decedent Ever in U. ned Forces? Yes 2 M No /es, Give ar or Dates:		Was Decedent of Hispanic I Yes, specify Cuban, Mex 1 ☐ Yes 2 ANO Spec		ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
within iene.	Completed	8th	pleted) illege (1-4or 5+)	(Give life.	dent's Usual Occupation kind of work done during in DO NOT use retired)  BORER			PRIVATE	dustry
Waryland a d 2 should be filed th and Mertal Hyg 7 is marked other traumatic event,	To Be	17. Father's Name (First, Middle, Last)  SAM THOMAS  19a. Informant's Name/Relationship (Type, Pr	*		AN	NIE B	HEBRO	City or Town, State, Zip	
The lead		BETTY L. GREEN/SISTE  20a. Method of Disposition  1	20b. P	lace of Dispo	51st AVENUE sition (Name of natory or other place) NAT''L	1/30/2	te 2	PIARY LAND  10c. Location - City or To  LAUREL, MARY	
Dermit. Pages Department of Important: If Its eny Injury or or		21. Signature of Funeral Service Licensee  23a. Part1. Enter the disease, or complication shock, or heart failura. List only one cau	ll .	7	Name and Address of Factor 1997 LANDOVER	R ROAD	LANDOVE		
Physician / Medical pe executed be physician and busician and as the burial-Itansi	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  c	Septice Due to for as a consequence	yence of); rato yence of);	nock ry fails Heart	ure	ease		Interval Between Onset and Death
The law requires that the death certificate is the has been signed by the attending physicage 2 should be detached for use as the total	Physician/Med	in the past 12 months?	res, outcome of pregna ]Live birth 2   Fetal ]Pregnant at lime of de ] Unknown	death 3	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
w requires that been signed b	by	Part II. Other significent conditions contributi	ng to death but not resu	ulting in the u	nderlying cause given in P	art I.		cco use contribute to the	4
	e Completed	25. Was case referred to medical			26 P	lace of Death	24a. Was an autopsy performed 1 Yes 2	prior to co death? No 1 □ Yes	psy lindings available mpletion of cause of 25 No
ding Phy h. After this funeral d	ertification: To B	2 Accident investigation 3 Suicide 6 Could not be	l: 1 Alphatient 2 Date of Injury (Month, Day Year) Place of Injury - At ho	ER/Outpatier 28b. Time of Injury	DOA Other: 4 28c. Injury at Work?  M 1 Yes 2	Nursing Home 28	e 5 ☐ Residen id. Describe how	ice 6 Other (Specification) occurred	
Hospita 4 hours Funerel ely filled	O	29a. Certifier    Certifying Physicien:   Certifying P	building, etc. (Specify  To the best of my known the basis of examination	v) wledge, deall	n occurred at the time, date	e and place, an	City or Town,	State) use(s) and manner as s	tated.
To the P within 24 within 24 complete	Medical	29b. Signature and title of certifier  30. Name and addr 11 person who complete	ed cause of death (Item Ebrahimi	23a) (Type,	29c. License numb BA7960S	per TYY	mo   290	d. Date signed (Month,  den 24  IVERDALE, MA	Day, Year) 2006
Sta Regist	ate rar	31. Date filed (Month, Day, Year)  JAN 2 7 2006	Registrar's Signa	/	K)		22,110	· · LIWALL , FIA	KILMIND ZO /

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				partment of Health and Mental Hygertificate of Death	giene 1.006	4050
			Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
	Physicia /Medic		WILLIAM SCOTT TAYLOR	FEBRUAR	Pay Year Y 05, 2006	7:30 A M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death	7.50 h
			CIVISTA MEDICAL CENTER	LAPLATA	CHARLES 9. Birthpla Countr	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 6. Sex 7. Age (In yrs.	Months Days Hours Min. (Month, Day		ce (State or Foreign y)
			Usuaf Residence of Decedent	AUG.9	,1943   KENT	UCKY
	yland		10a. State 10b. County 10c. City, Town or t	Location	100	d. Inside City Limits
	B Mar	ctor	MARYLAND CHARLES LA PLAT	ΓA		1 X Yes 2 No
	or 28	Dire	10e. Street and Number		10g. Citizen of What Countr	y?
	s 23a	Funeral Directo	#1 MAGNOLIA DRIVE	20646	U.S.A.	
	ter de Item	nne	11. Marital Status  12. Was Decedent Ever in U.S.   13 Armed Forces?  1 ☑ Never Married 2 ☐ Married   1 ☐ Yes 2 ☒ No	. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - Americar Black, White, et	
36	urs af	by F	3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2/CMo Specify:	Specify: WHI	TE
5-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Items 23a or 28a-f show ont, the Mudical Examinar must be modified at		15. Decedent's Education 16a. Dec	edent's Usual Occupation	16b. Kind of Business/Indu	stry
7	thin 7 en °n	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0·12) College (1·4or 5+)	e kind of work done during most of working DO NDT use retired)		
7	ed wi	Completed		ISABLED	N/A	
Maryland	d tai	Be	17. Father's Name ( <i>First, Middle, Last</i> )  JAMES SCOTT TAYLOR	18. Mother's Name (First, Middle, MYRTLE MC CO		
<u> </u>	should be and Mental a marked o	2				
<u>8</u>	12 h a 7 ls			ling Address (Street and Number or Rural Route Number)		
മ്	s 1 and of Health Item 27 other tr		20a. Method of Disposition 20b. Place of Disp	25 POPES CREEK RD., NET bosition (Name of bate	20c. Location - City or Tow	
Baltimore,			MADurial 2 ☐ Cremation 3 ☐ Removal from State  '4 ☐ Donation 5 ☐ Other (Specify)  NAZARENE (	ematory or other place)	DICCALL MA	DATAND
릁	permit. Page Department of Importent: If any injury or once.		NAARKUNE	CEMETERY 02-09-06  2. Name and Address of Facility	PISGAH, MA	RYLAND
ñ	Deg imig		M. 0 001	RAYMOND FUNERAL SERVIO	CE, P.A.	
			23a. Part1. Enter the disease, or complications that caused the death. Do noted shock, or heart failure. List only one cause on each fine.	the mode of dying, such as cardiac or respiratory ar	)646 est,	oproximate nterval Between
	Priysician	5 1	Immediate Cause (Final disease or condition a. RESPIRATO)	RY FAILURF		Onset and Death
	/Medical		resulting in death)  a  Due to (or as a consequence of):		_	
	Examiner		Sequentially list conditions, b. SMAI Bo	WEL ILEUS	H	WARS
44	sit ed	Examiner	rī any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
T	be executed ician and burial-transit	xan	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
3/PU	ate be e. hysician he buria	caiE	d		)),	
õ	fice p p	ed				
X Q Q		Physician/M	FFEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1 □ Live birth   2 □ Fetal death   3	□Ectopic pregnancy	23d. Date of delivery	
D	0 0 2	sicia	1 Yes 2 No	Other (specify)	Month D	ay Year
ī.	requires that the death een signed by the atter hould be detached for to	Phy	9 Unknown	One Didde		
JS,	ig.	by	Part II. Other significant conditions contributing to death but not resulting in the MUSCULAR CUSTROPHY		bacco use contribute to the es 2 □ No 3 □ Probab	
cords	v requ	etec	PRETITU			7
ě	e ta has	Completed	0,263114	24a. Was a autop perfor	sy prior to comp	y findings available letion of cause of
	sicien: The certificate herector, page	မ Co	25. Was case referred to medical	1 ☐ Yes	2 <b>79</b> No 1 □ Yes 2	□ No
<u>ত</u>		ă	examiner?  1 Yes 2 No Hospital: 1 A patient 2 ER/Outpatie	26. Place of Death (Check only or ent 3 DOA Other: 4 Nursing Home 5 Resid		
VII	/sici	0	Tripation Editionation		ance of Other (abecily)	
	shys this al di	$\vdash$	27. Manner of Death 28a. Date of Injury 28b. Time		ow injury occurred	
	shys this al di	$\vdash$	27. Manner of Death  Manner of Death  Month, Day Year)  28a. Date of Injury (Month, Day Year)  Injury	of 28c. Injury at 28d. Describe h Work?  M 1 Yes 2 No	ow injury occurred	
	shys this al di	$\vdash$	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	Work?  M 1	treet and Number or Rural F	Route Number,
	shys this al di	Certification; T	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	Work?  M 1	treet and Number or Rural F n, State)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Bertha Louise Thompson January 27, 2006 10:30A. /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery 8. Date of Birth (Month, Day, Year) Feb. 21, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under Months Days Hours 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 20 F 214-42-3850 97 1908 Mary1and Director Usual Residence of Decedent filed within 72 hours efter deeth with the Marylend 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 28a-f show Y⊟Yes 2 No Maryland Montgomery Gaithersburg Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 301 Russell Avenue 20877 U.S.A. Funera 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☼ No If Yes, Give 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ Specify: If Yes, Give Year or Dates: 3 ☑ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) treumatic event, the Medical 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home permit. Peges 1 end 2 should be file Depertment of Heelth and Mental Hy, importent: if item 27 is marked othe any Injury or other treumetic event, odgs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Plummer 2 Miles Carry McDonough 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Allen M. Thompson - Son 4813 N. Reyburn Court, Mount Airy, Maryland 21771 20c. Location - City or Town, State 20871 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Rurial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Hyattstown Meth. Cemetery 1/31/06 Hyattstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Molesworth-Williams P.A., Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20872 Approximate Interval Between anset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** plicenna al well /Medical Due to Vir as a consequence of): **Examiner** 20 umo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed for use as the burial-transit attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 PNo 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other. 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To SIL 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. nours efter death nere! Director: / filled in by the f 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours e To the Funerel I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 104115 V. Polests whether) 30. Name and address of person who completed cause of death (Item 2.a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

JAN 3 0 2006

32. Registrar's Signature

H. Robert Birschbach M.D.

06 Been & Speck

201 Russell Avenue, Gaithersburg, Maryland

20877

			1 - For State Registrar		/land / Dep	artme	ent of Health and ate of Death	d Mental Hy	giene 006	04052		
	Physic	ian	Decedent's Name (First, Middle, I	.ast)				2. Date of De Month	aath Day Year	3. Time of Death		
	/Med	ical	ROBERTA 4a. Facility Name (If not institution, g	WELC	H !	THOM		JANUZ				
	Exami	ner	Frederick Men		ital		y, Town, or Location of De ${ t rederick}$	ath	4c. County of Dea			
	Funeral	7	5. Social Security Number 6.		yrs. last birthday		ler 1 Year   If Under 24 H	rs. 8. Date of Bir	Freder			
l	Director		233-10-4308 Usual Residence of Decedent	1□ M 2□ <b>x</b> F 95		Month			29°, 1910°	rthplace (State or Foreign ountry) W VA		
	aryland show		10a. State 10b. County		c. City, Town or L				-	10d. Inside City Limits		
	the Maryla 28a-f shor	cto	MD Fred	erick	Fr	ede	rick			1 X Yes 2 □ No		
	hours after death with the Maryland tural; or frems 23a or 28a-f show at Examinar must be notitized at	Funeral Director	10e. Street and Number 1471 W. Key F	arkway C2		10f. Z	Zip Code 21702		10g. Citizen of What C			
	deat	ner	11. Marital Status	12. Was Decedent Eve	r in U.S. 13.	Was Dec	edent of Hispanic Origin? early Cuban, Mexican, Put	(Specify Yes or No				
9	or its	F.	1 ☐ Never Married 2 ☐ Marned	Amed Forces? 1 ☐ Yes 2X No If Yes, Give				erto Rican, etc.)		te, etc.		
903	urai',	d by	3 X Widowed 4 □ Divorced	Year or Dates:		1 1 105	2 No Specify:		Specify: W	hite		
7	nati	lete	15. Decedent's (Specify only highest g	Education rade completed)	(Give	kind of w	ual Occupation work done during most of w	rorking	16b. Kind of Business	/Industry		
12	withir ane. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired)					
d 2	be filed tal Hygic d other	ပို	17. Father's Name (First, Middle, Las		nu	rse	18 Mother's N	ame /First Middle	medical Maiden Sumame)	center		
an	Q 20 0	To Be	Robert						·			
Maryland 21215-0036	of of or or or or or or or or or or or or or	-	19a. Informant's Name/Relationship		19b. Maiti	na Addre	ss (Street and Number or I	uise Se.	Zin Code)			
	nd 2 salth ar		Charles Thoma	s (Son)			stchester (					
Baltimore,	of Healt item 2		20a. Method of Disposition	2	Ob. Place of Dispo	sition (N	arms of	Date	20c. Location - City or			
Ë	permit. Pages Department of I Important: If it eny injury or o	1 3	1 ☐ Burial 2 ☐ Cremation /B 4 ☐ Donation 5 ☐ Other (Spec	XRemoval from State	High La	wn N	Memorial 1,	/28/06	Oak Hill	TAT T7 A		
alti	mit. partm porta porta / Inju		21 Santhie of Funeral Price Lin						ouk hill	, W VA		
m	Depa Impo eny ti	31 E. Main St., Middletown, M										
			232 Part1. Enter the disease, or consider, or heart failure. List ont	nplications that caused the	death. Do not ent	er the mo	ode of dying, such as cardi	ac or respiratory a	rrest,	Approximate		
N	Physician		Immediate Cause (Final disease or condition		Interval Between Onset and Death							
	/Medical		resulting in death)	Due to (or as a co	nsequence of):					Bolayo		
	Examiner		Sequentially list conditions	b								
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	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с								
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9 ×	leath certific attending p	Physician/Med	IF FEMALE:	22a It was autoemo et e								
Box	atten for u	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetat death 3		pregnancy		23d. Date of de Month	ivery Day Year		
P.O.	the d	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊡Pregnant at time 9⊡ Unknown	ordeath 5	Other (s	specify)			54)		
	res that the de signed by the a be detached t		Part II. Other significant conditions	contributing to death but no	t resulting in the ur	nderlying	cause given in Part I.	23e. Did to	obacco use contribute to	the cause of death?		
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Re	he lav e hes ige 2	E C						autop	sy prior to death?	utopsy findin s available completion cause of		
<u>a</u>	ician: Th	ပိ	25. Was case referred to medical	15				1□ Yes	2 No 1 ☐ Yes	2 No		
Vital	ding Physician: The h. After this certificate he funeral director, page	To B	examiner?	Hospital:	2 ER/Outpatien		Other	ath Check on o				
ō	a Phy er this eral c		27. Manner of Death	28a. Date of Injury	28b Time of		28c. tnjury at		lence 6 Other (Speciow injury occurred	cify)		
Ö	nding F th. : After e funera	ig ig	1 ☑Naturat 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ar) Intury	м	Work? 1 ☐ Yes 2 ☐ No		on many oddania			
Division	Attendia r death. ector: A by the fu	Certification:	3 ☐ Suicide 6 ☐ Could not it	289. Place of Injury	At home, farm, stre	eet, factor		28f. Location (S	treet and Number or Ru	ıral Route Number		
Ö	al or s afte ii Dir	Sert	4  Homicide determined	building, etc. (S	oecify)			City or Ton	n, State)			
	To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transpace.	Medical (	29a. Certifier Cortifying P (Check only one)	nysician: To the best of my miner: On the basis of exal and manner stated.	knowledge, death mination and/or inv	occurred estigation	fat the time, date and plac n, in my opinion, death occ	e, and due to the curred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)		
	ompl	₹ e	29b. Signature and title of certifier			29	c. License number		29d. Date signed (Monti	h. Dav. Year)		
	C > P O		) (/a/l. /)	00		10	1000000					
	10		30. Name and address of person who	completed cause of death	(Item 23a) /Tune 1	Print\	000 00	UT	1-00-00	2		
	V			Sport 1847	THOULDS		100 00506 4W80N Dn 7	LEGERT	26 MIN 1	1765		
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	Registr	_	10 8 MAI	2006 Bene	B A	rode						

				Pepartment of Health and Mental Hygiene  Certificate of Death  Reg. No. 0 0 6 0 4 0 5 3
	Physici	an	1. Decedent's Name (First, Middle, Last)	2. Date of Death  Month Day Year  3. Time of Death
	/Media		Marguerite Hester Todd	January 24, 2006   4:10 p. <sup>™</sup>
-1	Examir	ner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  4c. County of Death
			Mallard Bay Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Cambridge Dorchester  Hoday   If Under 1 Year   If Under 24 Hrs.   8, Date of Birth   9, Birthplace (State or Foreign
	Funeral Director		4 DM obje	hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Pec. 9, 1913 Maryland
	pu k		Usual Residence of Decedent   10a. State   10b. County   10c. City, Town	
Ç	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "naturel; or Items 23a or 28a-f show other treumatic event, the Medical Ever in art must be profitted at	JO.	MD Dorchester	Cambridge 1 X ves 2 \( \triangle \) No
3	r 28a-	Funeral Director	10e. Street and Number	10f. Zip Code 10g. Citizen of What Country?
2	th with	a D	520 Glenburn Ave.	21613 USA
6	ems ems	ner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
36	or It	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 Married 1 ☐ Yes Give	1 ☐ Yes 2 ☑ No Specify: Specify: White
21215-0036	ture!	ed p	3'5 Widowed 4 □ Divorced Year or Dates:  15. Decedent's Education 16a. I	Decedent's Usual Occupation 16b, Kind of Business/Industry
215	hin 72 n "ne medik	Completed	(Specify only highest grade completed) (	(Give kind of work done during most of working life. DO NOT use retired)
21	filed will Hygiene other the	mo C	unknown	seamstress garment mfg.
Maryland	nould be filed within a Mental Hygiene. nerked other then natic event, the Ma	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
ryla	should Ind Menion Ind Menion	<sup>o</sup> L	John Odie Cannon  19a. Informant's Name/Relationship (Type, Print)  19b. 1	Eva A. Simmons
Ma	th and			Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  02 Edlon Park, Cambridge, MD 21613
ē,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If item 27 is marked other then any injury or other freumatic event, ILLA DAGE.	1 3	20a. Method of Disposition 20b. Place of I	U2 ECITOR Park, Cambridge, MD 21613 Date   20c. Location - City or Town, State
altimore,	Pages nent of 8 ant: If its ury or o		1 2-buriar 2 Cremation 3 Enemoval from State	ter Memorial Park 1/27/06 Cambridge, MD
alti	permit. Departm Importe any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Thomas Funeral Home P.A.
<b>B</b>	89E # 9		Brik. Br	700 Locust St., Cambridge, MD 21613
1			23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death
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9 ×	death certifica attending ph d for use as t		IF FEMALE: 23c. If yes, outcome of pregnancy	22d Date of delivery
Вох	atten I for u	cian	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)   23d. Date of delivery   Month Day Year
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S, P	res tha igned l be det	by P	Part II. Other significant conditions contributing to death but not resulting in the	the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
Vital Records,	w require been si should t	ted	CHICAGO HI INGTITUTA	1 Yes 2 No 3 Probably 4 Unknown
ecc	has be	Completed	CH+,	24a. Was an autopsy findings available autopsy prior to completion of cause of
		Con		performed? death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No
Vita	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:	26. Place of Death (Check only one)
of	Phys	: To	27. Magner of Death 28a. Date of Injury 28b. Tir	patient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)
ion	nding l ath. r: After e funer	atior	1 Natural 5 □ Pending (Month, Day Year) Inj 2 □ Accident investigation	jury Work? M 1 □ Yes 2 □ No
Division	after death after death Director: /	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	m, street, factory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)
	itel o			V
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical		death occurred at the time, date and place, and due to the cause(s) and manner as stated.  /or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day, Year)
			Mahhter Mo	D0063359 1/27/06
-			30. Name and address of person who completed cause of death (Item 23a) (T	
			MANDADA HKhter 30	COAurora St. CAMbridge Md 21613
:	Sta Registr	-	31. Date filed (Month, Day Year) 7 2006 32. Redistrar's Signature	Spark V

			1 - For State Registrer	State of	Maryland / Dep	ertment of Fertificate of	Health and		giene Reg. No. 006	04054
	Dhusia		1. Decedent's Name (First, Middle,	Last)		1 11		2. Date of Dea		3. Time of Death
	Physic /Medi		Arthur R. V					Januar	y 28, 20	0610:45p M
1	Exami	ner	4a. Facility Name (If not institution,		ber)	4b. City, Town, o	or Location of De	ath	4c. County of D	
			24 Brownfield  5. Social Security Number		. Age (In yrs. last birthday	E1kt			Ceci1	
	Funeral Director		159-03-7953	1 <b>3</b> M 2 □ F	. Age (III yrs. last birthday Yrs.	Months Days	Hours M	in. (Month, Da	Voor	Birthplace (State or Foreign Country) 916 PA
	ס		Usual Residence of Decedent					septem	Jer J, I	916 PA
	urylan show	_	10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	8e-f s	Director	MD Ceci	. 1	E1kt	on				1 ☐ Yes 🎇 ☐ No
	with ti	급	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?
	s 23	eral	24 Brownfield	Loop 12. Was Decede		219			U.S.A.	
·^	fter d	Funeral	1 Never Married 2 Married	Armed Force	es?	If Yes, specify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
8	el', o	by	3 Widowed 4 □ Divorced	If Yes, Give Year or Date	T. 17.7 7 7	1 ☐ Yes 2 ☐ No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. then "neture!; or Items 23e or 28e-f show its Madical Examirer in ust be notified at	Completed	15. Decedent's (Specify only highest	Education		dent's Usual Occup			16b. Kind of Busine	ss/Industry
12	vithin hen	ld m	Elementary/Secondary (0-12)	College (1-4	or 5+) life.	kind of work done of DO NOT use retired	1)	rorking		
	filed v Hygie Sther t		11 17. Father's Name (First, Middle, La			achinis			Aero Se	rvice
aryland	ld be f ental h ked of	Be c		51)				ame (First, Middle,		
<u> </u>	2 should be and Mental le marked eumatic ev	2	Alfred Veit  19a. Informant's Name/Relationship	(Tyne Print)	19h Maili	ng Address /Street		Augusta	Kintz r, City or Town, State	
≥	iges 1 and 2 should be filed within 72 hours after death with the Marylan nt of Health and Mental Hygiene. If item 27 le marked other then "neturel", or Items 23e or 28e-f show or other treumatic event, Its Madical Examiner is ust be notified at		Barbara Riede							
altimore,	s 1 al if Hea item othe	1	20a. Method of Disposition		20b. Place of Dispe	osition (Name of			ton, MD	21921 or Town. State
E	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 `4 ☐ Donation 5 ☐ Other (Spe		118	matory`or other plac rris Inc			•	ester, PA
a	permit. Pages Department of I Importent: If it any injury or of		21. Service Lice	ensee	2	2. Name and Address	ss of Facility Z	006		sster, ra
<u>m</u>	89 = 88							Funeral •• Elkto		21921
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that cau ly one cause on each	sed the death. Do not en	ter the mode of dying	g, such as cardi	ac or respiratory arr	est,	Approximate Interval Between
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	/Medical Examiner		resulting in death)	Country (of	as a consequence of):	23				- / ///////
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8/60	cate be executed physician and the burial-transit	dical		Coron	114 MAI	1 die	all			>Sycals >Sycar
9		0	IS CELLULE							
ROX	death certifi e attending   d for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor		Ectopic pregnancy			23d. Date of d	elivery
	0 0 0	sici	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		at time of death 5	Other (specify)			Month	Day Year
r Ö	that the de led by the a detached f		Part II. Dther significant conditions	contributing to do ath	a bust most generalities in the con-	4.1.				
ds,	se ig	d by	COPD A-fih	de his	rution resulting in the a	nderlying cause give	en in Part I.			to the cause of death?
cord	> 40	ete	0,2,1,0	on right	10/13					
Ě	The taw ate has b page 2 sl	ompleted						24a. Was ar autops perform	y prior to	autopsy findings available completion of cause of
Vitai	sicien: Th certificate rector, pag	e C	25. Was case referred to medical					1 ☐ Yes 2	No 1 □ Ye	
	Physicien: this certific ral director,	OB	examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ıtient 2 ☐ ER/Outpatien	t 3 DOA Othe	er.	ath (Check only one Home 5 Reside		ecity) ASSISTO
10	ng Ph ter th neral	n: T	27. Manner of Death 1 ☑Natural 5 ☑ Pending	28a. Date of Ir (Month, L	njury 28b. Time of	28c. Injury Work	at	28d. Describe ho		LIVING
VISION	eath. or: A the fu	catle	2 Accident investigation	on	,,,		es 2 □No			
<u> </u>	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not determined	289. Place of i	Injury - At home, farm, streetc. (Specify)	et, factory, office		28f. Location (Str City or Town,	eet and Number or F State)	Rural Route Number,
_	pitel ours a erel [	OF	700 Contilion 1 1 1 2 1 1 1 1 1					1	ŕ	
	To the Hospitel or Attending Phys within 24 hours after death.  To the Funerel Diffector: After this completely filled in by the funeral dir	edical	29a. Certifier  (Check only one)  1 Certifying P  2 Medical Exa	nysicien: To the bes miner: On the basis and manner:	st of my knowledge, death of examination and/or inv	occurred at the time estigation, in my opi	e, date and place inion, death occ	e, and due to the ca urred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	omple	Me	29b. Signature and title of certifier	1	stated.	29c. License	number	29	d. Date signed (Mon	th. Day Year)
	. , , , ,		1 /1		1/1	mis	-070			
1	i IVA		30. Name and address of person who	mpleted cause of	death (Item 23a) (Type, I	Print)	100	1 30	MUUNI	30. DCCC
L	7 1 7"		Ronce Perkis	10 1116	J. Itah SI	SUIF	314 E1	kton. M.	0 2192	<b>'</b>
	Stat		31. Date filed (Month, Day, Year) JAN 3 1 2006	32. Regis	trar's Signature		-			
	Registra	II.	~~~ 3 T 7002 73	COLUMN JO	A COUNTY					

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene () Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Virginia W. Vaughn FEB 02, 2006 0400 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 23251 Gilpin Point Road Preston

If Under 1 Year | If Under 24 Hrs.

Months Days | Hours | Min. Caroline 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1□ M 2□ F 93 Yrs. Sept. 11,1912 Director 160-10-2947 Maryland Usual Residence of Decedent permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event. I'm Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ₩ No MD Caroline Director Preston 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 23251 Gilpin Point Road 21655 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Acme Markets Cannery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Uriah A. Willev ဂ Ada McCready 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Priscilla V. Sellers/Daughter 23251 Gilpin Point Rd., Preston, MD 2165\$ 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Land State 4 Donation 5 Dother (Specify) Unity-Washington Cem. 02/06/06 Hurlock, Maryland 22. Name and Address of Facility Framptom Funeral Home, P.A. 21. Signature of Funeral Service Licenses Milail 7-Ecken 216 N. Main St., Federalsburg, MD 21632 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause og each line. Immediate Cause (Final disease or condition resulting in death) Concestives **Physician** Teas /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9□ Unknown ል s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Osevarthetis certificate 1 Yes 2N No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No this After thi 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation filled in by the fu 2 ☐ Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours e To the Funerel [ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 Mussel a Silve H42581 02/02/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Easton MA PLUSSELL A Schilling 20 535 Cynnood Av 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** Ruth Elizabeth Wainright 11:30 PM 30 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Nursing & Rehab Center Berlin Worcester If Under 1 Year Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea. 1/13/1913 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral**  Birthplace (State or Foreign Country) Min. 1 ☐ M 2 🕱 F Hours 93 Director 213-22-5802 MD Usuel Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "netural", or iteme 23s or 28s-f ehow the Medical Examiner must be notified at 1 Yes 2 No Director Wicomico Willards 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 36885 Old OCean City Rd. 21874 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. offied within 72 hours after dual Hygiene.

Other then "netural", or item Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Š Specify White 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Nurse Health Care if Health and Mental Hygie item 27 is marked other i other traumetic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be Joshua Powell Nancy Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Joshua Thomas Wainright 36885 Old Ocean City Rd., Willards, MD 21874 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages ō 1 GBurial 2 ☐ Cremation 3 ☐ Removal from State ö Dependent of important: If any injury or once. 4 □ Donation 5 □ Other (Specify) Riverside Cemetery 1/4/2006 Liberty town, MD 22. Name and Address of Facility The Burbage Funeral Home 21. Signature of Funeral Service Licensee 234. Part1. Enter the bisease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician Cardiomyopathy** years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a nonsequence of attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 **X** No Month 4☐Pregnant at time of death 5 Other (specify) P.0. ed by the detached 9 Unknown s been signed to should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ atrial fibrillation 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No dementia 1 ☐ Yes 2**X** No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DDA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2X No ţ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: el or Attending P s efter death. i Director: After t d in by the funera Division 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funeral L 29a. Cartifier X Certifying Physinian. To the best of my knowledge ideath occurred at the time, date and place, and due to the cases(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) DE 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2-106 30. Name and address of person who completed causa it reath (Item 23a) (Type, Print) ORIFFIN MO KKISTIME 1209 COAST FEWLACK ISLAND, DE 19944 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 1 2006

			1 - For State Registrar	State of	Maryla	ind / Depa	artmer <i>rtificat</i>				-	giene	00	6	040	57
	Physic /Med		Decedent's Name (First, Middle, La MADELYN O.	WRIGI	нт						2. Date of De Month JANUARY	ath Day	2	Year 006	3. Time of 13:3:	
	Exami		4a. Facility Name (If not institution, giv Montgomery Ger	neral Hos	spital			Olne	-			4c.	County MO:	ol Death ntgor		
·	Funeral Director		5. Social Security Number 6. S 217-44-2692 1  Usual Residence of Decedent	ex □M 2XIF	. Age (In yr	s. last birthday) Yrs.	Months .	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da Feb. 2	y, Year)	23	Cou	place (State on ntry) ryland	
	sa-f ehow	Director	Md. 10b. County Md. Monto	omery	10c. 0	City, Town or Lo Gaithe		rg							10d. Inside C	ity Limits 2 No
	ath with the 23a or 24		10e. Street and Number 24215 Woodfiel	d School	l Road	1	10f. Zip	Code 20882	2			10g. Citiz Uni		Vhat Cour	,	
9003	d within 72 hours after death with the Maryland jiene. In then "nature!", or iteme 23a or 28a-f show the Madical Exprinter result to notified at	d by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Deced Armed Ford 1 Yes 2 II Yes, Give Year or Dat	es? (X)No	1	Was Deced if Yes, spec 1 ☐ Yes		spanic Ori n, Mexican Specify:	gin? (Spe ), Puerto	ecify Yes or No Rican, etc.)			k, White,	can Indian, etc. nite	
21215-0036	within ne.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4	for 5+)	/// // // // // // // // // // // // //	dent's Usua kind of wo DO NOT us 7S1Ca	rk done d se retired	uring most		n <i>g</i>			siness/In	,	
Maryland	permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: if item 27 ie marked other t enty injury gcother traumatic event, III once.	To Be	17. Father's Name (First, Middle, Last)  Walter Chro						La	ura	(First, Middle, Musgr	ove				
e, Ma	1 and 2 sl Health and Sm 27 ie r ther traur		19a. Informant's Name/Relationship (7 Eugene W. Wrig  20a. Method of Disposition			4399	Adan	n Cou		Mt.	Airy,	Md.	2]	L771		
Baltimore,	rtment of transmit if its		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	)	ate	Place of Dispo- cemetery, cren emptown	ceme	ther place etery	,	1/3	1/06	Kem	ptow	-	own, State Iarylar	nd
Ba	Derm Depa Impo		21. Signature of Funeral Service Licen  Muruel  23a. Part 1. Enter the disease, or competitive or head failure. Lice only	N. Ba	erhe		P. C	). E	ox 50	38.	Funera Layton	svill	ne Le,	Md.	20882	2
	Company of the provided physician and physician and Examiner site purish transit support the provided physician strength and physician st	Examiner	shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underhying Cause (Disease or injury that initiated events resulting in death) Last	a. SE  Due to (or  Due to (or	PSIS as a conse	quence of): DIUM DI quence ol):					r respiratory ar	rest,			Approximate Interval Betv Onset and D 5 Day	veen Death
O. Box 68760,	The law requires that the death certificate be etter the has been signed by the attending physiciar bage 2 should be detached for use as the buri	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	d	me of pregn	ancy	Ectopic pre Other (spe					23	d. Date Mont	ol delive		ear
Records, P.O.	w requires that been signed I should be det	þ	Part II. Other significant conditions co	ntributing to deat	h but not res	sulting in the un	derlying ca	use giver	in Part I.						e cause of de	
		Completed	RENAL FAILURE								24a. Was a autops perford	med?	pr de	or to con ath?	esy findings a pletion of car	vailable use of
Vital	Physician: this certifical	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital:				04			(Check only or					
	1	<b>⊢</b> ⊦	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of In		ER/Outpatient 28b. Time of Injury		c. Injury a Work?	4 LINUIS	28	ne 5 Reside 8d. Describe ho				)	
DIVISION	spital or Atten ours after deat neral Director: filled in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building,	Injury - At h etc. (Specil	ome, farm, stre	et, factory,	office		28	81. Location (St City or Town	treet and f n, State)	Vumber	or Rural	Route Numb	Θ <i>r</i> ,
	To the Hospital or within 24 hours after To the Funeral Director Completely filled in b	Medicai	29a. Certifier (Check only one)	sician: To the be ner: On the basis and manner	o oi examina	owledge, death ation and/or inve	estigation, i	n my opir	nion, death	place, ar	nd due to the ca d at the time, d	ause(s) ar ate and pl	nd mann ace, an	ner as sta d due to	ited. the cause(s)	
6	5 ± € 8		29b. Signature and little of certifier					D O	number 06168	31	2	9d. Date s JANU			2006	
	===		30: Name and address of person who co ROBERT KIRKCALI	DY, M.D.	18:	101 PRI		HILI.	P DR.	, #3	32, OLN	NEY,	MD.	20	0832	
	Sta Registra		31. Date filed (Month, Day, Year)  JAN 3 0 200		strar's Signa	ature Age 4										

State of Maryland / Department of Health and Mental Hygiene 14058 For State CT Registrar Amend #23a. Prt. 1. Per Phys. PGC 2-3-06 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician ALVESTER WINFORD WARREN JANUARY 22, A M 2006 8:54 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CLINTON PRINCE GEORGE'S 6104 WILLOW WAY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeal) 948 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 ☐ F Yrs. DECEMBER 11 WASHINGTON DC 57 Director 578--60-5385 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f ehow the Medical Exeminer must be notified at 1 X Yes 2 □ No Director MD PRINCE GEORGE'S CLINTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò 6104 WILLOW WAY 20735 U.S.A. or items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status e filed within 72 hours after de Hygiene. other than "neturel", or item Black, White, etc. Amed Folces:
1 XYes 2 No
If Yes, Give
Year or Dates: VIETNAM 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: BLACK ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10th Fed. Special Police Officer Government other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Importent: if item 27 is marked othe eny injury or other treumatic event, 9068. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ROY WARREN MARY BIGGUS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANICE WARREN/WIFE 6104 WILLOW WAY CLINTON, MARYLAND 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State CHELTENHAM, MARYLAND 1/30/2006 MARYLAND VETERAN 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final disease or condition resulting in death) COLON CANCER **Physician** /Medical Due to (or as a consequence of) Examiner DIABETES MELLITUS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760 ettending physician Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of deliver 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X ☐ Unknown Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ⚠ No certificate 1 Yes **X** No Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 ☐ Yes 2🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending 1 ☐ Yes 2 ☐ No death. investigation after death Director: / 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide To the Hospitel o within 24 hours aft To the Funeral Di completely filled in 1 X Conflying Physician: To the best of my knowledge death occurred at the time date and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24s Carrier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier M.D. - Wad leis #D0031411 JANUARY 23, 2006 30. Name and address of person who completed caute of death (Item 23a) (Type, Print) VA MEDICAL CENTER 50 IRVING STREET NW, WASHINGTON, DC 20422 ROBERT WADLEIGH, M.D., 31. Date filed (Month, Day, Year) State 7 Registrar

		1 = For State Registrar	State o	f Maryla		artment <i>rtificate</i>			and M	lental Hy	giene Reg. No	UU	6	04059
		1. Decedent's Name (First, Middle, Las	t)		· · · · · ·					2. Date of De	ath			3. Time of Death
Physic /Medi		ROSEMARIE		WHI	TE					Month JANUAR	Y 19		<sub>Уеаг</sub> 006	11:25A
Exami		4a. Facility Name (If not institution, give		mber)		4b. City, To	own, or	Location o	f Death		4c.	County	of Death	
		PRINCE GEORGE'						CRLY					CE G	EORGE'S
, Funeral Director		00, 20 00,0	x □M 2120 F	7. Age (In yrs	s. last birthday) Yrs.	If Under 1 Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da DECEMB	h y, Year) ER 1	.935	9. Birth Cou NEW	place (State or Foreig ntry) YORK
pur *		Usual Residence of Decedent  10a. State 10b. County		100 0	ity, Town or Lo									
be filed within 72 hours after death with the Maryland tal Hygiene. d other then "naturel", or Itams 23a or 28e-f show event. The Madical Eventher mat be multiped at	5													10d. Inside City Limits 1 X Yes 2 □ No
28e-	Director	MD PRINCE G	EORGE'S	U	PPER MA	ARLBORO 10f. Zip C					10 000			
3a or	0	13400 VANDIVER O	OHRT			207					U.S	izen of W	rnat Cou	ntry?
deatr ms 2	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	J.S. 13.			spanic Orio	in? (Spe	ecify Yes or No- Rican, etc.)			a - Ameri	can Indian.
or its	Ē	1 ☐ Never Married 2 X Married	Armed Fo 1 ☐ Yes	24 No	1				Puerto	Rican, etc.)			k, White,	etc.
	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da			1⊡Yes <b>2</b> €	J No	Specify:				Specify:		BLACK
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and le m		19a. Informant's Name/Relationship (T	· . · · · · · ·	ID						I Route Numbe				
Heal In 2		WILLIE L. WHITE  20a. Method of Disposition	HUSBAI				100000	k COU.		_				YLAND 2077
Department of Important: if Ite any injury or of one		1 ⊠Burial 2 ☐ Cremation 3 ☐ I		State	Place of Dispo cemetery, cren	natory or othe	r place			ate				own, State
rtant	9	4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens		MT	. OLIVE				./27,			INGT		
Depa Impo any i		21. Signature of Pulleral Service Cicens	1 - /	0	- 11	. Name and A		,		. B. JEI				
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nysician Medical xaminer		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. META	ASTATIO or as a consec	BREAS'	r carc				,				Interval Between Onset and Death
ansit	Examiner	Caquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events												
physician and s the burial-transit	dicai Exa	resulting in death) Last  Due to (or as a consequence of):  d.												
signed by the attending p d be detached for use as	0	Lob. Has decedent pregnant	3c. If yes, outo	ome of pregnanth 2 Feta		Ectopic pregr	ancu				2	3d. Date	of delive	ery
y the at	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		int at time of c		Other (special						Mont	th	Day Year
ned b	by Pt	Part II. Other significent conditions con	ntributing to dea	ath but not res	uiting in the un	derlying caus	e given	in Part I.		23e. Did to	bacco us	se contrib	oute to th	ne cause of death?
been sig should be										1 🗆 Y	es 2[	No 3	B 🗆 Prob	ably 42 Unknown
s bee	Completed									24a. Was a	n	24b. W	ere auto	nev findings available
te has	Eo									autons		_ ae	ain?	psy findings available repletion of cause of
certificate rector, pag	a	25. Was case referred to medical						26. Place o	of Death	1 ☐ Yes :		1[	Yes	2KI No
this ce	To B	examiner? 1 Tes 2 No	lospital: 1 🔀 In	patient 2	ER/Outpatient	3□ D0A	Other:			e 5 ☐ Reside	-	Other	(Specifi	()
fter	atlon:	27. Manner of Death 1 X Natural / 5 ☐ Pending 2 ☐ Accide#t Investigation	28a. Date of		28b. Time of Injury		Injury a Work? 1  Ye		2	8d. Describe ho				/
el Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of building	of Injury - At ho g, etc. <i>(Specif</i>	ome, farm, stre	et, factory, of	fice		2	8f. Location (St City or Town	reet and n, State)	Number	or Rura	Route Number,
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medicai (	29a. Certifier (Chack only one) 1 Certifying Physical Examini	sician: To the b	sis or examina	wledge, death liion and/or inv	occurred at the	ne time, my opin	date and non, death	place, ar occurre	nd due to the ca d at the time, d	ause(s) a ate and p	and manr place, an	ner as st d due to	ated. the cause(s)
To T	Σ	29b. Signature and title of certifier		^		29c. Li	cense n	number		2	9d. Date	signed (	Month, L	Day, Year)
0		MIN	Joyce			D-	178	74			JANU.	ARY	20,	2006
18/		30. Name and address of person who co	mpleted cause	of death (Item	n 23a) (Type, P	rint)			_					
		S.M. NAYAR M.D.			Committee of the Commit		ity	, Mar	ylar	nd 20722	2			
Stat	PER CAR	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signa	ture	e								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Adeline Elizabeth Wines January 30, 2006 12:30 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charlotte Hall Veterans' Home Charlotte Hall St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug. 7, 1920 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** Months Days 1 ☐ M 2 🖾 F Hours Yrs. Director Aug. Virginia 85 579-10-0838 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 28a-f ehov other than "naturel", or Items 23s or 28s-f ehovent, the Medical Examiner must be notified at 1 Yes 2 No Directo Monmouth New Jersey Freehold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5203 Biltmore Drive 07728 USA by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 11 Clerk Retail 27 le markad othe traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Carl G. Printz Winnie Phoebe Wilt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health a ftem 27 I other tra Melvin G. Wines, Sr. - Husband 5203 Biltmore Drive, Freehold, NJ 07728 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State ± 5 Department of Important: If eny injury or once. 2-2-2006 4 ☐ Donation 5 ☐ Other (Specify) Huntt Crematory Waldorf, MD 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 3035 Old Washington Road M00053 Huntt Funeral Home Waldorf, MD 20601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary **Physician** Advanced disease or condition resulting in death) Disease /Medical Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury s a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed nemia that initiated events resulting in death) Last Due to (or as a consequence of P.O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown been signed to should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No teoporosi's 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has I lirector, page 2 s autopsy performed? Dementia 2 HO 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ 46 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No the 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by within 24 hours after or To the Funeral Direct completely filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45092 30. Name ind address of person who con pleted cause of death (Item 23a) (Type, Print) #205 Prince Tredrick, MD 20678 110 HOSPI tou 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

			1 - For State of Registrar	Marylan		artment of H rtificate of L			ieņe g. No. ()	06	04061
	Physici	an	1. Decedent's Name (First, Middle, Last)  Maurice A Way	al				2. Date of Deat Month	Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and num,	1		4b. City, Town, or	Location of Death		2. <del>4</del> 4c. Co	unty of Death	6:45AM
	LXamin	CI	Baltimure Reliabilitation		1 Care	Baltima	re				
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 □ F 777-16-5411  Usual Residence of Decedent	Age (In yrs. i	last birthday) Yrs.	If Under 1 Year Months Days	tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 8-22-19	Year)	Cou	place (State or Foreign ntry) yland
	yland		10a. State 10b. County	10c. City	y, Town or Lo	ocation	<u> </u>			1	10d. Inside City Limits
	e Maria	ctor	Maryland Anne Arundel		Severn	a Park					1 ☐ Yes 2 🛣 No
	with th	Directo	10e. Street and Number			10f. Zip Code 2114	c	1		of What Cou	ntry?
	ns 23	Funeral	83 Barrensdale Drive  11. Marital Status  12. Was Decedanged For	ent Ever in U.	S. 13.	Was Decedent of Hi		pecify Yes or No-	-	USA Race - Americ	can Indian,
020	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Items 23s or 28s-f show mary figury or other traumatic event, the Macical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 X Yes 2	□No		If Yes, specify Cubai	n, Mexican, Puerti Specify:	Rican, etc.)		Black, White, ecify: Wh	etc. iite
ה כ	72 ho	eted	15. Decedent's Education (Specify only highest grade completed)		(Give	dent's Usual Occupa	luring most of wor	king	16b. Kind	of Business/In	dustry
7	within ene. than	Completed	Elementary/Secondary (0-12) College (1-8th	tor 5+)		DO NOT use retired, b Driver	)		Τ.	iverv	
2	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, Last)			O DIIVEI	18. Mother's Nam	ne (First, Middle, I			
yla	should band Ments marked	To E	William J. Waugh				Li	ulie D. I	Hearl	d	
<u> </u>	d 2 shu thand 7 is m traum		19a. Informant's Name/Relationship (Type, Print)			ng Address (Street a			-		
ກັ	s 1 and f Health itam 27 other tr		Clarence M. Waugh/ Son 20a. Method of Disposition	20b. P	lace of Dispo	arrensdale esition (Name of matory or other place	1			ion - City or To	
altillog a	Pages nent of ant; If it		1 <b>X</b> Burial 2 □ Cremation 3 □ Removal from S 4 □ Donation 5 □ Other (Specify)	are		ans Cemete	· 1	7–06	Chel	tenham,	, MD
סמור	permit. Departr Importe any inje		21. Signature of Funeral Service Licensee			2. Name and Addres					
ı	Physician		23a. Part1. Enter the disease, or complications that ca shock, or heart failure. List only one cause on ea Immediate Cause (Final	ch line.	n. Do not en	er the mode of dying	g, such as cardiac	or respiratory arre			Approximate Interval Between Onset and Death
	/Medical		resulting in death)  a.   The property of the	r as a consequ	uence of):	ic Hear	Dista	5.6			MKNOWK
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Ď X O	ding p	/Mec	IF FEMALE: 23c. If yes, outc	ome of oregna	DCV						
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ני	a law r has be e 2 sh	Completed						24a. Was a autops	y _	prior to co	psy findings available mpletion of cause of
	n: The ficate or, pag	e Col	25. Was case referred to medical						No	death? 1 ☐ Yes	2□ No
N I G	ysicia s cert directe	To Be	examiner?Hospital:	patient 2 🗆	ER/Outpatie	nt 3□ DOA Othe	AC.	th <i>(Check only on</i> ome 5 ☐ Reside		Other (Specif	(v)
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VISION	ttendi death. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	Alaine Alba			fes 2 □No	206 Leasting /Co			- Court No - to
2	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2	Certification:	4 Homicide determined buildin	g, etc. ( <i>Specit</i> y	y)	reet, factory, office		City or Towr	n, State)		al Route Number,
	the Hosp in 24 ho the Fune npletely f	fedical	29a. Certifier  (Check only one)  Certifying Physician: To the lagger one)  Medical Examiner: On the bar and manning and manni	is of examinal	wledge, deat tion and/or in	vestigation, in my op	pinion, death occu	rred at the time, d	ate and pla	ice, and due to	the cause(s)
)	To To cor	M	29b. Signature and title of Certifier	dy	) ma	29c. License 343 Print) Boulevay				igned (Month,	
			30. Name and address of person who completed cause	of death (Item	23a) (Type,	Print)	10 14	in a la	, /	1 -	1010
<b>3</b> ):	Sta	te	31. Date filed (Month, Day, Year) 37 Re	gistrar's Signa	ture	Poul-l'ar	ו אמבון אינ	MOYN, BI	angle	and 2	1215
200	Registr	ar	JAN 2 7 2006	m B	1	W.			V		
DH	MH 17 Rev 1/2	001			-						

Testate Registrer  Certificate of Death  Reg. No.  1. Decedent's Name (First, Middle, Last)  EDWARD LEONARD WALTER  Examiner  EDWARD LEONARD WALTER  4a. Facility Name (If not institution, give street and number)  1 0660 LA PLATA ROAD  LA PLATA  CHARLE  Funeral Director  2. Date of Death Month PEBRUARY 2, 2  4b. City, Town, or Location of Death  4c. County of Charles  The Physician Month Day FEBRUARY 2, 2  4b. City, Town, or Location of Death  4c. County of Charles  The Physician Month Day FEBRUARY 2, 2  4c. County of Charles  The Physician Month Day FEBRUARY 2, 2  4c. County of Charles  The Physician Month Day Hours Min. B. Date of Birth (Month, Day, Year) JULY 28, 1924	
Physician //Medical Examiner  EDWARD LEONARD WALTER  4a. Facility Name (If not institution, give street and number)  10660 LA PLATA ROAD  LA PLATA  CHARLE  Funeral  5. Social Security Number  6. Sex  VTYM 2DF  7. Age (In yrs. last birthday)  Months Days Hours Min.  Month FEBRUARY 2, 2  4b. City, Town, or Location of Death 4c. County of Charles (If Under 1 Year If Under 24 Hrs. Months)  Month FEBRUARY 2, 2  4c. County of Charles (If Under 1 Year If Under 24 Hrs. Months)  Months Days Hours Min.  Month FEBRUARY 2, 2	3. Time of Death
4a. Facility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of LA PLATA   CHARLE	Voor
10660 LA PLATA ROAD  LA PLATA  CHARLE  Funeral  5. Social Security Number  6. Sex  17. Age (In yrs. last birthday)  Months Days Hours Min.  Months, Days Hours Min.  (Month, Day, Year)	
Months Days Hours Min. (Month, Day, Year)	
	Birthplace (State or Foreign Country)
	4 MARYLAND
Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
MARYLAND CHARLES LA PLATA	1 □Yes XXNo
10e. Street and Number 10f. Zip Code 10g. Citizen of W	Vhat Country?
MARYLAND CHARLES LA PLATA  10e. Street and Number  10f. Zip Code  10g. Citizen of W  10g. Citizen of W  10g. Citizen of W  10g. Citizen of W  10g. Citizen of W  10g. Citizen of W  10g. Citizen of W  10g. Citizen of W  11g. Was Decedent Ever in U.S. Amed Forces?  11g. Was Decedent Ever in U.S. Amed Forces?  11g. Was Decedent Ever in U.S. Amed Forces?  11g. Was Decedent of Hispanic Origin? (Specify Yes or No-  11g. Was Decedent Figure 1. Specify Cuban, Mexican, Puento Rican, etc.)  11g. Was Decedent Ever in U.S. Amed Forces?  11g. Was Decedent Figure 1. Specify Cuban, Mexican, Puento Rican, etc.)	Δ
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No-Hispanic Origin) (Specify Yes or No-Hispanic Origin) (Specify Yes or No-Hispanic Origin) (Specify Cuban, Mexican, Puerto Rican, etc.)	e - American Indian, k, White, etc.
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15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of But (Give kind of work done during most of working life. DO NOT use retired)  17	.siness/industry
College (1-4or 5+)  Elementary/Secondary (0-12)  College (1-4or 5+)  HOME BUILDER  OWN S	SELF
17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame	
HARRY H. WALTER EMMA HECKEL	
The state of the s	State, Zip Code)
20a. Method of Disposition    Comparison   C	City or Town, State
SACRED REART CEM.   02-06-06 LA PLA    Compared to the properties of Facility   10   10   10   10   10   10   10   1	ATA, MD
	. A •
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate
Immediate Cause (Final disease or condition LV CAY CER	Interval Between Onset and Death
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			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day	V	3. Time of	Death
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	Examin		4a. Facility Name (If not institution, give street and number)			4b. City, Town, or	Location of Deat	h	4c. County	of Death		
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	Funeral		Frederick Memorial Hospita 5. Social Security Number 6. Sex	(In yrs. last birt	hday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year)	9. Birthp	lace (State o	r Foreign
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	D >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	orlo	ation					0d. Inside C	ih Limito
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	er de Item	Funeral	11. Marital Status  12. Was Decedent E Armed Forces?		13. V	Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	Specify Yes or No- to Rican, etc.)		r. Ameno c, White,	ean Indian, etc.	
9	s aft	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 1 ☐ Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1973	1	☐ Yes 2√7 No	Specify:		Specify.	Wh	ite	
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther then "naturel", or Reme 23s or 28s-f ehow ent, the Medical Examinar must be notified at		15. Decedent's Education	16a.	Deced	ent's Usual Occupa	ation	1	6b. Kind of Bu	siness/In	dustry	
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Maryland	2 should be and be and be and and and and and and and and and and	1/4	19a. Informant's Name/Relationship (Type, Print)	19b.	Mailin	Address (Street a	and Number or A	ural Route Number,	City or Town,	State, Zip	Code)	
	12 E E		Eric Allen Wagner - Son	22	4 W	estside A	venue,	Hagersto	wn, Mar	y1an	id 21	740
ē.	of Hee		20a. Method of Disposition	20b. Place of cemeter	Dispo:	ition (Name of atory or other place	e)	Date 2	Oc. Location -	City or To	own, State	
Ĕ	Pages nent of int: If It iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Bethes	da	Methodist	Cemete	ry 1/30/0	6 Damas	cus,	Mary!	Land
altimore,	교육원들 .		21. Sign ture of Funeral Service Licensee	)	M22	Name and Address	s of Facility	s P.A., F	uneral	Home		
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	Physician		Immediate Cause (Final disease or condition	hazk	1 2	a. N. L	R	LINE +:	, (		Onset and	
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E	o dea	SICI	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown	ime of death		Other (specify)			Moi	าเท	Day	Year
<u>Ч</u>	et the	۴	9 Li Unknown									
	The law requires thet the death certificate hes been signed by the attending page 2 should be deteched for use as	b	Part II. Other significant conditions contributing to death bu	t not resulting ir √	the u	iderlying cause give	en in Part I.		acco use conti			
ğ	w requir been si should	ted	Losophon Brito	1	1	2018		1 U Ye	s 2 🗆 No	3 L Prot	bably 4 🗆	Jakaowa
ပ္ပိ	lawr es be 2 sh	Completed	137 per + C 1-1,	•				24a. Was ar autops	24b. \	Vere auto	opsy findings impletion of o	available
Œ	The ete h page	0						morred	ed?	leath?		
ita	artific ctor.	Be (	25. Was case referred to medical examiner?				26. Place of De	ath (Check only one	3)			
<u>-</u>	hysic lis ce	2	Hospital:	1 2 (XER/Ou	tpatien	t 3□ DOA Othe	er: 4 🗌 Nursing	Home 5 ☐ Reside	nce 6 □Oth	er (Speci	fy)	
Division of Vital Records,	fter ti		27. Manner of Death 1 Natural 5 ☐ Pending (Month, Day	Year) 28b.	Time of	28c. Injun Worl	y at k?	28d. Describe ho	w injury occurr	ed		
Ö	endli path. pr: A	Certification:	2 Accident investigation	į		M 1 🗆	Yes 2 □ No					
ž	r Att	± E	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju building, etc	ry - At home, fa . <i>(Specity)</i>	rm, str	eet, factory, office		28f. Location (Sti City or Town	reet and Numb , State)	er or Run	al Route Nun	nber,
	rs af											
	To the Hospital or Attending Physician: The lav within 24 hours after death.  To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	cai	29a. Certifier 1 Certifying Physicien: To the best of Medicat Examiner: On the basis of	examination an	dor in	occurred at the time timestigation, in my or	ne, date and place pinion, death occ	ce, and due to the ca	use(s) and ma	nner as s and due t	stated. to the cause(	s)
	the the the	Medicai	one) and manner stat	ed.		29c. License						
	₽¥₽ĕ ^		29b. Signature and title of certifier	-	-	290. Licenso	اهراسان م	2	9d. Date signed	i (ivionin,	Jay, rear)	
!	11/4	1	mh	1 -		W	30 I	V	1 1,	1]	00	
1	Dti		30. Name and address of person who completed cause of de	ath (Item 23a)	Дуре,	Print)	FINAL	0	1411	1	1201	
	1 -		31. Date filed Month Day Year) 38 Benistra	r's Signature	12	00	1 3.67.16	-WIN	1110		13/	
	Stá Registr		31. Date filed (Month, Day, Year) 32 Registra	A	Parent.	Carte d						

			For State Registra MEND#1perMD2/6	06,BMV,McCo	Cer	rtificate of L		d Mental Hyg	giene No. 006	04064
	Physici	an	1. Decedent's Name (First, Middle, Las	Nancy W	. Winter	berg		2. Date of Dea Month	ith Day Year	3. Time of Death
	/Medic	al	- Nancy	C. Win	terberg .		Landing of D	January		6:00 P. <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give			4b. City, Town, or		eatn	4c. County of Dea	
	Funeral	-	Wilson Health Car 5. Social Security Number 6. Se		(In yrs. last birthday)	Gaithe  If Under 1 Year	If Under 24 h	Hrs. 8. Date of Birth	Montgom 9. Bi	thplace (State or Foreign
	Director		220-18-2512	□M 2 <b>⊠</b> F	84 Yrs.	Months Days	Hours M	Min. (Month, Day Dec. 28	, 1921 Wes	ountry)
	pu ,		Usual Residence of Decedent		10c. City, Town or Lo					
	shov	2	10a. State 10b. County		,,					10d. Inside City Limits 1 X Yes 2 ☐ No
	28a-f	Directo	Maryland   Montgome	ery	Gaither	sburg 10f. Zip Code			10g. Citizen of What C	
	with with			- # 010			7			
	death ms 23	Funeral	403 Russell Avenu	12. Was Decedent Ev	ver in U.S. 13.	2087 Was Decedent of Hi		? (Specify Yes or No- uerto Rican, etc.)	United S	erican Indian,
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2X No	)	lf Yes, specify Cuba 1 □ Yes 2 2X No		uerto Rican, etc.)		ite, etc.
8	within 72 hours after death with the Maryland ene. than "naturel", or Items 23a or 28a-f show ta Madical Exertinal Le notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		TEL TES ZEALNO	Specily.		Specify: Wh	ite
<u>2</u>	"natu	Completed	15. Decedent's Ed (Specify only highest grad		(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of	working	16b. Kind of Business	s/industry
12	withir ane. than	dmo	Elementary/Secondary (0-12)	College (1-4or 5+	)		,		Frederick	
0 0	Hygid Hygid other ent, II	ပိ	17. Father's Name (First, Middle, Last)	<u>Эт</u>	Read.	ing Speci		Name (First, Middle,	Public Sc Maiden Surname)	noois
<u>a</u>	lid be lental ked o	To Be	Kemp D	. Swick	er			Margar	et C. Ca	mpbell
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or Items 23a or 28a-f show any igury or other treumatic event, the Madical Extr. in et and be notified at some		19a. Informant's Name/Relationship (7	урө, Print)	19b. Mailir	ng Address (Street a	and Number of	r Rural Route Numbe	r, City or Town, State,	Zip Code)
Σ	and 2 Balth a m 27 Is		Ronald Winterberg/	Husband					ersburg, M	
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	20b. Place of Dispo cemetery, crer	sition (Name of matory or other plac	e)	Date	20c. Location - City o	r Town, State
E	Pages Iment of Hant: If the Jury or of		*4 □ Donation 5 □ Other (Specify	)	Metropoli	tan Crema	itory 1	/26/2006	Alexandria	Vircinia
3a	permit. Departr Importa		21. Signature of Funeral Service Licen	50% 0 ().	1.0.4			DeVol Fund		
	40148		23a. Part1. Enter the disease, or comp	dications that caused t					thersburg,	MD • 208// Approximate
8760,	Physician be executed by second by s	dical Examiner	shock, or heart failure. List only of disease or condition resulting in death)  Sequentially list conditions, any leading to miniocate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Aduel Due to (or as a b. Atsh Ona to Fras a c.	consequence of):  consequence of):  consequence of):	use to Is des	nei	ive		Interval Between Onset and Death Que month
O. Box 6	ath certific attending p for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at t	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	slivery Day Year
ds, P.	ires that the de signed by the a d be detached t		Part II. Other significant conditions of		t not resulting in the u		en in Part I.		obacco use contribute	to the cause of death?
Record	w require been sig should b	Completed by	disease	Jup 17	2111	9)	Sagi	24a. Was	an 24h Were a	utopsy findings available
Re	φ <u>c</u> <u>e</u>	тр	Calmadin		2	Land	/	- autop	rmed?/ prior to death?	completion of cause of
Vital	icien: Th certificate rector, pag	e Cc	25. Was case referred to medical	ruen	oses"	yperce		Death (Check only o		s 2□No
	ysiclen: is certific director,	To B	examiner? 1 \( \text{Yes}  2 \( \text{No} \)	Hospital:	t 2 ER/Outpatier	nt 3□ DOA Oth			dence 6 Other (Sp.	ecify)
סר	モ モニ	T : U	27. Manner of Death	28a. Date of Injury (Month, Day	Year) 28b. Time o				now injury occurred	-,,
<u>50</u>	r Attending P ler death. rector: After t by the funera	atlo	1 Natural 5 Pending 2 Accident investigation		Today Injury		Yes 2□No			
Division of	or Attency after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc.	ry - At home, farm, str (Specify)	reet, factory, office		28f. Location (5 City or Tox	Street and Number or F vn, State)	Rural Route Number,
	pitel ours al		200 Contilies 1 Continue Blo	il	f and the standard st	the account of the size				3
	To the Hospitel or within 24 hours after To the Funerel Direction completely filled in I	Medical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	niner: On the basis of and manner state	examination and/or in	ivestigation, in my o	pinion, death c	occurred at the time,	cause(s) and manner a date and place, and du	is stated. se to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier			29c. Licenso			29d. Date signed (Mor	
)			V. Robert	Birsch	benefin	us Do	24115	5 1	Januar	125,2006
	8		30. Name and address of person who a LAROBERT B	completed cause of de	ath (Item 23a) (Type.	Print) 201	RUS	SELLAU	CNUE 1 NA 20	125,2006 877
	Sta Registi		31. Date filed (Month, Day, Year) JAN 2 7 2	32. Degistra	r's Signature	och				

			For State Registrar		Marylan		artment rtificate			and Me		giene Neg. No. 0	06	04065
1	Physici	an	Decedent's Name (First, Middle,	enry Geor	ree 7AD	משתוום				1	Date of Dea Month		2006	3. Time of Death 2:00 A M
	/Medio Examin		4a. Facility Name (If not institution,			KUDEK	4b. City, T	own, or i	_ocation o		anuar		unty of Deat	
1	Lxaiiii	CI	10 E. Lenox Str	eet			Chevy	Cha	se			Мо	ontgom	ery
	Funeral Director		456-52-3406	.Sex 1∏ M 2□ F	7. Age (In yrs. I 67	ast birthday) Yrs.	If Under Months	Days	If Under a	24 Hrs. 8. Min. Ma	Date of Birtl (Month, Day 1rch 28	3, 193	9. Birt Co Ne	thplace (State or Foreign buntry) W York
	show	or.	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgo	mery	10c. City	r, Town or Lo	ocation evy Ch	ase				10d. Inside City Limits 1 ☐ Yes 2 ☑ No		
	the N	rect	10e. Street and Number				10f. Zip					10g. Citizer	n of What Co	
	738 or	al Di	10 E. Lenox Stre	et				20	815		:	Unit	ted St	ates
036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Heelth and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show amount injury or other treumetic event. I're Medical Eventher man be notified at ODGe.	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4 Divorced	Armed For	2∭No e		Was Decede If Yes, speci 1 Yes 2			gin? (Specif i, Puerto Ric	y Yes or No- can, etc.)	No- 14. Race - American Indian, Black, White, etc.  Specify: white		
Baltimore, Maryland 21215-0036	within 72 ho ene. then "natur re Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0·12)	Education grade completed) College (1- 5+	-4or 5+)	(Give	dent's Usual kind of work DO NOT use	k done du a retired)	ion <i>Iring m</i> ost	t of working			of Business/	/Industry
מ	other	Be C	17. Father's Name (First, Middle, La		h		COLITO		18. Mothe	r's Name (F	irst, Middle,			
<u>Jar</u>	Menta Menta arked	To B	Abraham Za	pruder					Lil	llian	Shapov	nick		
, Mar	and 2 sho selth and n 27 ts mv er treume		19a. Informant's Name/Relationship Marjorie Zaprude				-				Chase,	-	own, State, 2 20815	Zip Code)
lore	t of He if iten		20a. Method of Disposition 1 ∑Burial 2 □ Cremation 3		State	lace of Dispo emetery, cre	matory or oti	her place,		Date			tion - City or	
<u>=</u>	artment ortent: injury		*4 □ Donation 5 □ Other (Special Structure of Fundamental Service Li		Mt.	Leban							phi, M	עו
g	Depril Impo		PE		5						neral I Washir		DC.	20012
	Physician		23a. Part1. The disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on ea	used the death ach line. blastom	n. Do not en	ter the mode	of dying	such as	cardiac or re	espiratory ar	rest,		Approximate Interval Between Onset and Death Yr 4 month
	/Medical Examiner		resulting at deathy	Due to (	or as a consequ	uence of):								
	ned neit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	or as a consequ	rsequence of):									
8760,	icate be executed physician and s the burial-transit	dicai Exal	that initiated events resulting in death) Last C. Due to (or as a consequence of):											
.O. Box 68	ath certit attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		inth 2 ☐ Fetal ant at time of de	death 3	⊒Ectopic pre □ Other (spe					23d	I. Date of del Month	livery Day Year
1	uires that the de n signed by the a Id be detached t	by	Part II. Other significant condition	s contributing to de	eath but not resu	ulting in the u	inderlying ca	use giver	n in Part I.					the cause of death?
Division of Vital Records,	he law requ s has been ige 2 should	Completed				•					24a. Was autop	med?	prior to death?	utopsy findings available completion of cause of
a		a	25. Was case referred to medical						26. Place	of Death (C	1 ☐ Yes Check only o	2X No	1 Ll Yes	2□ No
of V	ding Phyeiclen: The la h. Atter this certiticate ha: tuneral director, page 2	n: To B	examiner? 1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending		npatient 2  of Injury h, Day Year)	ER/Outpatie		Other	at		5 <b>X</b> Resid			cify)
ivisio	To the Hospitel or Attending within 24 hours atter death.  To the Funerel Director: Atter completely tilled in by the tuner	Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - At ho	ome, farm, st	M reet, factory,		es 2 🗍 l	_	Location (S City or Tow		lumber or Ru	ural Route Number,
	To the Hospitel of within 24 hours all To the Funerel D completely tilled it	edical Ce										s stated. to the cause(s)		
	To the within 2 To the complet	Med	one) 29b. Signature and title of certifier	and mann		2	29c.	License D43			-		-	h, Day, Year)
,	15		30. Name and address of person w Robert S. Sie	no completed cause				Δ17.	NTI	J Lie	shinet		-	
	Sta	te	31. Date filed (Month, Day, Year)	32. Re	egistrar's Signa	ture			• , 147	, was	, ii zii g t (	, D	2003	
	Registi	ar	JAN 27	2006	albertan d	H. A.	sarli							

			For State Registrar		artment of Health and Nortificate of Death	Mental Hygie	2006 01.066
	Physici /Medic	_	1. Decedent's Name (First, Middle, Last)  JOSHUA	ABEOKUTO			Day Year 2 2006 6.26 A M
	Examin Funeral		4a. Facility Name (If not institution, give street a  UNIVERSITY OF MA  5. Social Security Number  2111 - 73 - 73   6. Sex	RYLAND  7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death  BALTIMORE  If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth	4c. County of Death  NA  9. Birthplace (State or Foreign County)
1	Director		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Lo	ocation	sept. 1,	10d. Inside Oity Limits
	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hygiene. Item 27 is marked other than "natural, or items 23s or 28s-1 ehow other traumatic event, II a Medical Evacuration in the notified at	Funeral Director	Maryland NAT  10e. Street and Number  5205 W. North A	Ve.	Utimore 101. Zip Code 21207	10g.	1 ⊠Yes 2 □ No Citizen of What Country?  USA
980	ours after deat rai', or items? Evaninar mu	þ	1 Never Married 2 Married 1 H	Yes 2 ☑ No	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036	d within 72 ho giene. ir than "natur II.a Medical	Completed	15. Decedent's Education (Specify only highest grade comp  Elementary/Secondary (0-12)  Col	eted) 16a. Dece (Give life.	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	king 16b	. Kind of Business/Industry
Maryland	should be filed and Mental Hygis s marked other sumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Shaun Abeoku	O	18. Mother's Nam	e (First, Middle, Mail ha Payh	den Sumame)
-	1 and 2 sho Health and em 27 is mu ther trauma		19a. Informant's Name/Relationship (Type, Prin Shaun Abec/Kuto —	19b. Mailli 520 20b. Place of Dispo	ng Address (Street and Number or Full 5 W. Horth Al	re. Balti	nore Maryland
Baltimore	permit. Pages 1 Department of H Important: If Ite eny Injury or ot once.		20a. Method of Disposition  1 □ ourial 2 □ Cremation 3 □ Remova 4 □ Donation 5 □ Other (Specify)  21. Signature of Fungin Service Licensee	from State Arbutus	Mem. Hunk 21	7/06 A	Location - City or Lwn, State Listus Mariland Home
	40199	V /	23a. Part1. Enter the disease, or complications shock, or heart failure. List only one caus	that caused the death. Do not enter on each line.	STZ FRACTICK F Iter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
ge.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit are by	edical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	LYPERKALEMI ue to (or as a consequence of): SEPTIC SHOCK us to (or as a consequence of): CRAH POSITIVE ue to (or as a consequence of): EXTREME	<		AL FAIWRE
.O. Box (	that the death certifica led by the attending ph detached for use as th	Physician/Me	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
ords, P.	w requires that i been signed by should be deta	b	Part II. Other significant conditions contributing	g to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobac 1 ☐ Yes	co use contribute to the cause of death?  2 No 3 Probably 4 Unknown
Vital Records,	iician: The law certificate has b rector, page 2 st	Completed				24a. Was an autopsy performed	
×.	ysicia is certi directo	To Be	25. Was case referred to medical examiner?  1 Yes 2 No Hospital	1 Inpatient 2 ER/Outpatien	Other	th (Check only one) ome 5 ☐ Residenc	e 6 □Other (Specify)
Division of	ending Physician: The sath. or: After this certificate he funeral director, page		2 Accident investigation	Date of Injury (Month, Day Year) 28b. Time of Injury		28d. Describe how	
Divis	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fi	Certification:	4 Homicide	Place of Injury - At home, farm, st building, etc. (Specify)		City or Town, S	
	24 hos 24 ho e Fund etely f	Medicai	(Check only 2 Medical Examiner: Or	To the best of my knowledge, deat the basis of examination and/or in dimanner stated.	th occurred at the time, date and place avestigation, in my opinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
)	To th within To th comp	Me	29b. Signature and title of certifier		29c. License number P 1866 4	29d.	Date signed (Month, Day, Year) 2/12/06
	2			22 S areene	sheet, UMMS,	Baltim	ore, MD
*	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	<i></i>		
DH	IMH 17 Rev 1/2	001	1 CD T = 5002	Misses & A	o <b>sele</b> NAL		

		. For	State of Marylan						•
		1 - State Registrar		Ce	ertificate of L	Death		Reg. No. 0 0 6	04067
Physic	ian	1. Decedent's Name (First, Middle, Last)			-		2. Date of De	ath Day Yee	3. Time of Death
/Medi		Agnes Ellen Ashby					TEBRUA	RY 11 200	6 10-20AM
Exami		4a. Facility Name (If not institution, give s	٠٨.	$\gamma$	4b. City, Town, or	Location of De	ath	4c. County of De	<b>\</b>
Francis		5. Social Security Number 6. Sex		LE NTE		If Under 24 H	NIE rs. 8. Date of Bir	th a r	RUNDEL Bithplace (State or Foreign
Funeral Director			M 2DXF 85	Yrs.	Months Days	Hours M		y, Year) 21 M	Country)
P .	- Company	Usual Residence of Decedent  10a. State 10b. County	140- 60						T
aryla Pho	20			y, Town or I					10d. Inside City Limits 1 ☐ Yes 2 X No
the M	Director	MD Anne Arun	del G	len B	urnie 10f. Zip Code			10g. Citizen of What	
deeth with the Maryland ma 23a or 28a-f ahow court be notified at	۵	510 Stanhome Drive			21061			U.S.A.	oountry :
deeth	Funeral		12. Was Decedent Ever in U.	S. 13	. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin?	(Specify Yes or No		merican Indian,
DESILIMOYE, MATYIANG ZIZIS-UUSO permit. Peges and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Merital Hygiene. Important: if Item 27 is marked other than "natural", or Itema 23a or 28a-f ahow any injury or other traumatic avant, the Madical Examinat must be notified as once.	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:	erto Hican, etc.)	Black, W Specify: W	
72 hg	etec	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dec	edent's Usual Occupa e kind of work done of DO NOT use retired	ation during most of v	vorking	16b. Kind of Busine	ss/Industry
Mithin Mithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			)		Conors	l Business
filled v Hygie Ither I	ပိ	17. Father's Name (First, Middle, Last)		Sale	S	18. Mother's N	lame (First, Middle	Maiden Sumame)	II busilless
VIANG	To Be	Charles Hittel					s Bushman	,	
shoul nd Ma	F	19a. Informant's Name/Relationship (Type	oe, Print)	19b. Mai	ling Address (Street a			er, City or Town, State	a, Zip Code)
nd 2 sh and 2 sh alth and 27 is m		Mr. Daniel Ashby /	son	363	2 Metavish	a Ave.;	Baltimor	e, MD 2122	.9
or series		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ R	20b. P		osition (Name of ematory or other place		Date	20c. Location - City	
Peg ment ant: B		4 Donation 5 Other (Specify)	Mar		Veterans		-16-2006	Crownsvil	
Daltimore, permit. Peges at Department of Hea mportant: if Item my injury or othe		21. Signature of Funeral Service License					-	Funeral H	-
40240		10000	une Mo13					rnie, MD 2	
		23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on Immediate Cause (Final	490					rrest,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a conseq		AR AC	CIDEA	ノナ		4 DAYS
Examiner		f.	Due to (or as a conseq.	uence or).					
D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):					
ecute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D						
rou, te be executed ysicien end e burial-transit	calE		Due to (or as a consequ	uence or);					
VICE INSCRICTS, F.O. DOX 00/00, sicien: The law requires that the death certificate be executed certificate has been signed by the attending physicien end rector, page 2 should be detached for use as the burial-transit	_	d	•						
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death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown		□Ectopic pregnancy □ Other (specify)			Month	Day Year
of the dach the stach	Phy	9 Unknown							
res th	ρ	Part II. Other significant conditions con	tributing to death but not resi	ulting in the	underlying cause give	en in Part I.			to the cause of death?
w requires been sign should be	eted						- 10'		Probably 4 Unknows
hest yess	Completed				<del></del> -		24a. Was	osv prior t	autopsy findings available o completion of cause of
n: Th	ပို	25. Was case referred to medical					perfo 1 ☐ Yes	2 X No 1 □ Y	es 2 No
VISION OF VICE Attending Physician: In death. ector: Atter this certific by the funeral director,	0 8	examiner?	ospital: 1 X Inpatient 2 □	ER/Outpatie	ent 3 DOA Othe		Home 5 Pesi	one) dence 6 □Other(S)	
ding Phys	<b>-</b>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time			- 4	how injury occurred	овспу)
Badin G	atlo	1 Natural 5 ☐ Pending investigation	(World), Day 16al)	Injury		Yes 2 □ No			
DIVISION  JONE Attending after death.  Director: After din by the fune	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify		treet, factory, office		28f. Location (. City or To	Street and Number or wn, State)	Rural Route Number,
To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificete h.	edical C	29a. Certifier (Check only one)  Check only one)  Certifying Physical Examination (Check only one)	ician: To the best of my kno ler: On the basis of examina and manner stated.	wledge, dea tion and/or i	ath occurred at the time nvestigation, in my op	ne, date and pla pinion, death oc	ice, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. lue to the cause(s)
To th Within To th	Me	29b. Signature and title of certifier	1		29c. License	number		29d. Date signed (Mo	onth, Day, Year)
		I felher the	the, no		D 00	60796	7	2/11/200	7) 4.
10		30. Name and address of person who co			p, Print)		BURNEE,		
0			05 HUSPETAL		, *305, 6	SCEN E	SURNEE,	mo 210	61
	استرز	21 Date filed (Manch Day V)	20 0 - 64 1 2						
Sta Regist		31. Date filed (Month, Day, Year) FFR 1 4 2	32. Registrer's Signa	ture	1.00				
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			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.
e A	Physici /Medic	al	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day 2 was 3. Time of Death Month Ob 2 was 4. County of Death 4c. County of Death 4c. County of Death 4c. County of Death 4c.
*8	Funeral	er	Mercy Medical Couter Baltimore BALTIMOR BALTIMOR CITY  5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign County) 1 Months Days Hours Min.
×	Director  wow  led	tor	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  3al Hmore City  1xyes 2 No
21215-0036	within 72 hours after deeth with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow he Midical Exerciting robal be notified at	Completed by Funeral Director	10g. Citizen of What Country?  2
Maryland	nd 2 should be filed alth and Menta! Hygi 27 le merked other r treumatic event.	To Be Con	17. Father's Name (First, Middle, Last)  WH KNOWN  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Te 'Naula Ayd Lett — Mother 2865 Ricos Wenue Millian Milli
Baltimore,	permit. Pages 1 a Department of Hes Important: If Itam eny Injury or othe		20a. Method of Disposition    Burial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)   Vew Carrelland   3/3/2006   Dal to emetery, crematory or other place)  21. Signature   Foregal Service icc. see   22-tame and Address of Facility   Foregal Home, P.A.    And Inc.   Now Sarry & Rd.   Lizzz
0,	Physician /Medical Examiner and pnual-transit	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause is each line.  Approximate Interval Between Onset and Death  Due to (or as a consequence of):  Sequentially list conditions, any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
, P.O. Box 68760,	The law requires that the death certificate be executed as been signed by the attending physicien and page 2 should be detached for use as the burial-transit	y Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2 No 9   Unknown   23c. If yes, outcome of pregnancy 1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   4   Pregnant at time of death 5   Other (specify)   Month Day Year   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death 3   Ectopic pregnancy   Month Day Year   4   Pregnant at time of death 5   Other (specify)   Month Day Year   23c. Did tobacco use contribute to the cause of death?
Division of Vital Records,	: The law requires cete has been sign , page 2 should be	Completed by	FRETERM (Abo)?  1 Yes 22No 3 Probably 4 Unknown  1 Yes 22No 3 Probably 4 Unknown  1 Yes 22No 3 Probably 4 Unknown  24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 22No 1 Yes 2No 1 Yes 2No
sion of Vita	To the Hospitel or Attending Physician: The I within 24 hours efter death. To the Funeral Director: After this certificete ha completely filled in by the funeral director, page	ertification: To Be	25. Was case referred to medical examiner?  1
Divi	To the Hospitel or Attending F within 24 hours efter death. To the Funeral Director: After completely filled in by the funer	edical Certifi	3 Suicide 4 Homicide  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28f. Location (Street and Number or Rural Route Number, City or Town, State)  28g. Certifier (Check only one)  28g. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28g. Place of Injury - At home, farm, street, factory, office City or Town, State)  28g. Location (Street and Number or Rural Route Number, City or Town, State)
)	To the within To the comple	Med	29b. Signature and title of certifier  C. J. Awyor ND  29c. License number  D Z 9 Z 9 9  0 1 0 6 Z & 6
	Sta Registi		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Awyr 301 S7 PAul AL, BALTi Move MD 21202  31. Date filed (Month, Day, Year)  32. Paistrar's Signature

		•	For State Registrar	State of Maryla		artment of H			giene	04.069
			Decedent's Name (First, Middle, Last)	0				2. Date of Dea	ath	3. Time of Death
	Physici /Medic		Charlene :	Due Uni	nani	e	Landing (Bas)	Februar L		
	Examin	er	4a. Facility Name (If not institution, give	street and number)			Location of Deat ore City	1	4c. County of Deat	n
_	Cupanal		Harbor Hospital  5. Social Security Number 6. Secur	7. Age (In yrs	s. last birthday)	If Under 1 Year	If Under 24 Hrs	8. Date of Birt	h 9. Birt	hplace (State or Foreign
	Funeral Director			M 2√C F 53	Yrs.	Months Days	Hours Min.	April	16,1952 Ma	aryland
	P.		Usual Residence of Decedent	100	VA. #					Last to the annual to the
	arylar ehow	_	10a. State 10b. County		City, Town or Lo	cation	-,	Dundalk		10d. Inside City Limits 1 ☐ Yes 2 No
	Ba-f	Director	Maryland Baltir	nore		10f. Zip Code			10g. Citizen of What Co	
	3a or	i D	7813 St. Patricia	a Lan <b>e</b>		Tot. Zip Code	21222		United St	í
	me 2	nera	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deperment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene Important: if Item 27 is marked other then "natural", or Iteme 23a or 28a-f show saft figury or other treumatic event, the Medical Examinat must be notified at once.	Completed by Funeral	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 VNo If Yes, Give Year or Dates:	į.	1 ☐ Yes Ž☐ No	Specify:	o moan, etc.)	Black, Whit	White
Š.	72 ho	ted	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	ation	rkina	16b. Kind of Business/	Industry
2	ithin	du	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	1)		T Mas	
7	ygier herth	ပ်	12 Years		A	ccounts R			Waste Mai	nagement
Maryland	ntal F ed of	Be	17. Father's Name (First, Middle, Last)					a Brande		
Ž	hould Mark mark	၉	Charles Spuduck  19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Maili	na Address (Street			er, City or Town, State, 2	Zip Code)
Z Z	ulth an 27 is		Mr. James Annanie		1	3 St. Pat			lalk, Maryl	
ē,	s 1 ar		20a. Method of Disposition	20b.	Place of Dispo	osition (Name of matory or other place	(e)	Date	20c. Location - City or	Town, State
E	Page nent o not: If iry or	١,	1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State (		ill Cemet		/2006	Baltimore	, Maryland
Baltimore,	permit. Depertru Imports eny inju		21. ign ture of Funeral Service Licens	ee Ca	/				Dundalk, I Maryland	nc. 21222
		V	23a Part. Enter the disease, or compl	ications that caused the de		7922 Wise ter the mode of dyin				Approximate
Į.	Physician		shock, or heart failure. List only or Immediate Cause (Final	1 . /-	111000	Aid .	Carnet	10-1		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a conse	LUDCAI		riface!	1070		
П	Examiner		Sequentially list conditions	atherosc	Gerot,	e hear	of disc	ease		
	p is	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):					
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Φ	tificat ng phy as th									
Вох	death certific e attending p id for use as	an/N	230. Was decedent pregnant	23c. If yes, outcome of preg		☐Ectopic pregnancy	,		23d. Date of de	
о. П	0 0 2	Physician/Me	in the past 12 months? 1 □ Yes     No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown		Other (specify)			Month	Day Year
<u>α</u>	that the by detact		Part II. Other significant conditions con	ntributing to death but not re	esulting in the u	inderlying cause giv	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
Vital Records,	requires that the een signed by th nould be detache	ed by						10,	Yes 2 No 3 P	robably 4 Munknown
000	S S S	Completed						24a. Was	an 24b. Were at	utopsy findings available completion of cause of
ž	ر م م	E O						perfo	rmed death?	2  No
/ita	sician: T certificat rector, pa	Be (	25. Was case referred to medical examiner?		/			ath (Check only o	one)	
<del>6</del>	\$ 0 17	မ	1 ☐ Yes 24 ☐ No		ER/Outpatie		4   Nulsing	·, · · · · · · · · · · · · · · · · · ·	dence 6 □Other (Spe	cify)
u C		lon	27. Manner of Death  1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor	yat k? Yes 2 ∐No	28d. Describe	how injury occurred	
Division	l or Attending effer death. Director: Afte i in by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At	home, farm, st				Street and Number or R	ural Route Number,
<u>S</u>	s efter	Certification;	4 Homicide	building, etc. (Spe	cify)			City or To	wn, State)	
	To the Hospital or Attenwithin 24 hours efter deatl To the Funeral Director:	Medical (	29a. Certifier Certifying Phy (Check only one)	sician: To the best of my kiner: On the basis of exami	nowledge, dear nation and/or in	th occurred at the tire	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and manner as date and place, and due	s stated. e to the cause(s)
	To the within 2 To the complet	Se Se	29b. Signature and title of certifier	Emerae	nen Pi	29c. Licens	e number		29d. Date signed (Moni	th, Day, Year)
	> - 0		1 Wino	Phile	CIA	D	46609		2/8	106
	1		30. Name and ad ess of person who co	eted cause of th (It	em 23a) (Type	Print)	0 11		. 8	4
	2		Dale Barnes M	D 3001 S	. Han	over St	Salti	1 Ene,	m1 21	225
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 4 2	32. Registrar's Sig	nature	Carle &				
	· J		1 4 4 4 4 4	ALCO COLO	All Sale	SHIP TO SHIP				

death.

Physician

/Medical

Examiner

Director

Funeral

**Funeral** 

Director

John Stauart Lebruar

21215-0036 Completed by Baltimore, Maryland 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be filt Department of Health and Mental Hy Important: if Item 27 is marked oth any lighry or other treumetic event 2008: Be James Robert-Kellie Bannister 19a. Informant's Name/Relationship (Type, Print) Eleanor Bannister, Wife 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner and I-transit certificate be executed resulting in death) Last physicien a Physician/Medical as the l attending p IF FEMALE: 23b. Was decedent pregnant in the past 12 months? signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Completed has certificate : After this certifica e funeral director, i 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death Certification: 1 Natural 2 Accident within 24 hours effer death.

To the Funeral Director: A completely filled in by the fu 3 Suicide 4 Homicide McCertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 25643 Name and address of person who completed cause of death (Item 23a) (Type, Print) Kendall Reviewer mD/6601 N. Chauses street 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jasele FEB 1 4 2006 Registrar DHMH 17 Rev 1/200 **ORIGINAL** 

Residence of Decedent tate 10b. County  land Anne And treet and Number  9 Telegraph Road  Initial Status Never Married 2 Married Widowed 4 Divorced  (Specify only highest ginentary/Secondary (0-12) 12  Ither's Name (First, Middle, Las wart Wayne Ballou Informant's Name/Relationship tricia Ballou/wif  Setto of Disposition Burial 2 Cremation 3 Donation 10 Other (Specignature)  Part Enter the disease, or corshock, or heart failure. List onfidiate Cause (Final se or condition ing in death)	ad #21  Sex 110 M 2 F  7.  110 M 2 F  12. Was Decede Armed Force 1 Tyes, Give Year or Date  Education trade completed)  College (1-40)  (Type, Print) e  Print Pri	Age (In yrs. 64  10c. Ci Se  ant Ever in U as?  X) No as:  or 5+)  20b. I I v	16a. Dece (Give life. Parts 19b. Maili 7959 1 Place of Disposemetery, cre y Hill (	Sev  If Und Months  10f. Z 21  Was Dec If Yes, so If Ye	ern Year  Tip Code  114  Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent of His Bedent Of His Bedent of His Bedent Of His Beden	sof Facility  ring Ro	in? (Spec Puerto Ri 's Name (ie Ree or Rural Seven Da 2/10/2	First, Middle ed Route Number Maryl te 2006	10g. Citiz Unite O- 1 16b. Kir Qua o, Maiden and 2' 20c. Loure	ten of What (d State)  4. Race - An Black, Who of Busines  1 ity Ele  Town, State  1114  cation - City (el), Mary	ath indel inthplace (State or For Country) I rginia  10d. Inside City Lin 1  Yes 2   Country?  America merican Indian, hite, etc. I/hite ess/Industry evator  or Town, State I/land
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wart Wayne Ballou Informant's Name/Relationship tricia Ballou/wife Idethod of Disposition Burial 2 Cremation 3 Cherry Donation Cherry Gnature Uneral Service Lice Part Lenter the disease, or conshock, or heart failure. List onfidiate Cause (Final se or condition ing in death)	(Type, Print) e  Removal from Stacify) ensee  mplications that cause on each	ised the death line.	7959 Telegraphic Place of Disposemetery, creeding Hill (2)	celegrosition (Nomatory or Ceme te 2. Name a 501 Sa	ss (Street a raph Ro- ame of other place rry and Address	William Number and #21  about the state of Facility aring Ro	or Rural Seven Da 2/10/2	Route Numbern Maryl te 2006	and 2' 20c. Loi Laure	Town, State 1114 cation - City o	or Town, State
tricia Ballou/wife  tethod of Disposition  Burial 2 Cremation 3 Other (Special Ponation 5 Other	PRemoval from Statify) ensee mplications that cauly one cause on each	ised the death line.	7959 Telegraphic Place of Disposemetery, creeding Hill (2)	celegrosition (Nomatory or Ceme te 2. Name a 501 Sa	raph Ro- ame of rother place ery and Address	ad #21  a)   2  as of Facility  ring Ro	Sever Da 2/10/2 Fle	n Maryl 10 2006 eck Fune	and 2° 20c. Lo Laure	1114 cation - City o	or Town, State
Donation Sil Other (Specification of Control	ensee  "mplications that cause on each	ised the death tine.	y Hill (	2. Name a 501 Sa ter the mo	and Address	s of Facility	Fle	ck Fune	eral Ho	ome	
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shock, or heart failure. List onf diate Cause (Final se or condition ing in death)	a	touta	etic		ode or dying		ardiac or	ure 1 Mary 1 and 20707 respiratory arrest, Approximate Interval Between			
entially list conditions, leading to immediate . Enter Underlying 5 (Disease or injury itiated events ing in death) Last	c	as a consec		Tail	ung	, Co	nce	<u>R</u>			Sinsel and Deat Single of 3 mos
MALE: Was decedent pregnant n the past 12 months?  Yes 2 \ No	23c. If yes, outco 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	h 2 ☐ Feta ntat time of d	al déath 3[	⊒Ectopic ⊒ Other (s	pregnancy specify)				2	23d. Date of d Month	delivery Day Year
Other significant conditions	contributing to deat	th but not res	sulting in the L	inderlying	cause give	en in Part I.			,		to the cause of death
								auto	ormed?	24b. Were autopsy findings avair prior to completion of cause death?  No 1 Yes 2 No	
as case referred to medical :: :aminer? Yes 2x No	Hospital: 1 ☐ Inp	patient 2	] ER/Outpatie	nt_3 🗆 🖸	Othe					S ☐ Other (S <sub>I</sub>	pecify)
27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 1 Injury 2 Accident investigation M							28d. Describe how injury occurred			Rural Route Number,	
Certifier 1 Certifying F (Check only 2 Medical Extended)	aminer: On the basi	is of examin	owledge, dear ation and/or in	th occurre	ed at the tim	ne, date and pinion, death	place, ar	nd due to the	cause(s) , date and	and manner place, and d	as stated. lue to the cause(s)
Signature and title of certifier	- 4						413	•			
	is case referred to medical miner?  Yes No nner of Death Natural 5 Pending investigat Suicide 6 Could not determine  Pertifier 1 Certifying 2 Medical Eximature and title of certifier	Is case referred to medical miner?  Yes No Hospital: 1 Inn Inn	Is case referred to medical miner?    Yes	Is case referred to medical aminer?  Yes No Hospital: 1 Inpatient 2 ER/Outpatien	Is case referred to medical aminer?  Yes No Hospital: 1   Inpatient 2   ER/Outpatient 3   Inpatient 2   Inpatient 3   Inpatient 2   ER/Outpatient 3   Inpatient 2   ER/Outpatient 3   Inpatient 2   ER/Outpatient 3   Inpatient 2   Inpatient 2   ER/Outpatient 3   Inpatient 2   ER/Outpatient 3   Inpatient 2   Inpatient 2   Inpatient 2   ER/Outpatient 3   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 3   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 2   Inpatient 3   Inpatient 2	Is case reterred to medical aminer?  Yes No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cthe Commer of Death Natural 5 Pending Investigation Accident Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  Sertifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time Check only and manner stated.	Is case referred to medical aminer?  No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nur nner of Death Natural Accident Suicide Homicide  Suicide Homicide  1 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and content of title of certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	Is case reterred to medical aminer?  No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Homoner of Death Natural 5 Pending Investigation Accident Solicide Getermined 28e. Place of Injury - At home, farm, street, factory, office 28e. Place of Injury - At home, farm, street, factory, office 29e. Verifier Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  26. Place of Death Chent 4 Nursing Hom Virtual 28e. Injury at Work?  1 Yes 2 No 1 Nursing Hom Virtual 29e. Injury at Work?  1 Yes 2 No 2 No 2 Nork?  1 Yes 2 No 2 Nork?  1 Yes 2 No 2 Nork?  1 Yes 2 No 2 Nork?  28e. Place of Injury - At home, farm, street, factory, office 29e. Verifier 20 Nork?  29c. License number 29c. License number	24a. Was autoperful yes  Is case reterred to medical autoperful yes  Is case reterred to medical autoperful yes  In control Death (Check only autopation)  Natural Accident Suicide Germined  28a. Date of Injury (Month, Day Year)  Suicide Germined  28a. Date of Injury (Month, Day Year)  28b. Time of Injury at Work?  Injury at Wor	24a. Was an autopsy performed?  1 Yes No  Its case reterred to medical aminer?  No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Cther: 4 Nursing Home 5 Residence 6 Injury at Work?  Natural Accident Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office 28e. Location (Street and City or Town, State, 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and and manner stated.	24a. Was an autopsy performed? 1 Yes XX No  24b. Were proformed? 1 Yes XX No  24c. Place of Death (Check only one)  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other: 4 Nursing Home 5 Residence 6 Other (S)  nner of Death (Natural of Death of Dea

		1 - For State Registrar	Otat	e or mary	and / Depa <i>Ce</i>	rtificate			-	giene Regino	06	04072	
Dhunini		1. Decedent's Name (First, Mid	idle, Last)			2			2. Date of De. Month	ath Day	Year	3. Time of Death	
Physicia /Medic		NETTIE				BAKE	ER		FEBRUAR				
Examin		4a. Facility Name (If not institut	ion, give street ar	nd number)	CENTER		own, or Locat		7		ounty of Dea		
		JOHNS HOPKING	3 BAYVIE	EN CAR		BAL	TIMO	RE		BA	LTIME	DRE CITY	
Funeral		5. Social Security Number	6. Sex 1 ☐ M X2 ☐	7. Age (In )	rs. last birthday,		Year If Un Days Hou	nder 24 Hrs. urs Min.	8. Date of Bird (Month, Da Aug 1,	th v. Year)	9. Bi	rthplace (State or Forei	
Director		231-34-0189	I I M AL	9 9	6 Yrs.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Aug 1,	1909		Virginia	
>		Usual Residence of Decedent  10a. State 10b. Coun	ah.	100	City, Town or L	coation						10d. Inside City Limi	
of other then "natural", or itams 23a or 28a-f show event, the Medical Examiner outst by notified at	5	Maryland	N/A	100.	Ony, TOWN OF L	ocation	Baltimo	re				Yes 2 N	
28a-f	Director	10e. Street and Number	147.1			101 7 0				40- 00-	- (144) - 1 (1	1	
Bor	급	5013 Schaub Avenu	ue.			10f. Zip Co		206		iog. Cilize	on of What C	•	
ns 23	Funeral	11. Marital Status		Decedent Ever i	olis 13	Was Deceder			nacify Vas or No	- 14	1 Bace - Am	erican Indian,	
THE L	S	1 Never Married 2 M	Arm	ed Forces? Yes 2X No	10.3.	If Yes, specify	y Cuban, Me	xican, Puert	pecify Yes or No o Rican, etc.)		Black, Wh		
XBH	by	3€ Widowed 4 Divorc	. If Ye	s, Give		1 ☐ Yes 2X	No Spe	city:		5	Specify:	Black	
岩			ent's Education		16a. Dece	edent's Usual (	Occupation			16b. Kind	d of Busines	s/Industry	
treumatic event, <u>tre Medic</u>	Siet	(Specify only high	hest grade comple		(Give	DO NOT use	done during	most of wor	rking			•	
Neg.	Completed	Elementary/Secondary (0-12	2) Colle	ege (1-4or 5+)			lomemal	ker			Own	Home	
	ပိ	12 17. Father's Name (First, Middle	le, Last)				18. N	fother's Nar	ne (First, Middle,	. Maiden S	lumame)		
	00	N	athan Faltz							rances	,		
9	င	19a. Informant's Name/Relatio	nehin /Tuna Prin	t)	10h Mail	inn Addraes (S	Street and No	imber or Ri	ıral Route Numb	or City or	Town State	Zin Code)	
treu		Barbara Jackson D		.,		_			ore, Maryla	_		21p (000e)	
any injury or other treumatic		20a. Method of Disposition		20	b. Place of Disp			T	Date			r Town, State	
0		1X Burial 2 ☐ Crematio	n 3 Removal		cemetery, cre	matory or othe	er place)	1	02/17/06			, Virginia	
		`4 □Donation 5 □Other			,	n National		1	02/1//00		ampton	, viigiilia	
ouce		21. Signaturant Funeral Service	ce Licensee	85/	A S	2. Name and Este - 1300	Brothe	rs Fune	ral Service,	P. A. 21217	6		
		23a. Part1. Enter the disease, shock, or heart failure. L	or complications	that caused the c	leat D not en							Approximate Interval Between	
an		Immediate Cause (Final	ist only one cause		1							Onset and Death	
al al		disease or condition resulting in death)	a	EME									
er				de to (or as a con	sequence or,								
	ē	Sequentially list conditions, if any, leading to immediate	b	ue to (or as a con	sequence of):		-						
	ü	Cause. Enter Underlying	<										
Ŋ	Examine	that initiated events resulting in death) Last	c	ue to (or as a con	sequence of):								
	a E												
	dical		d										
	/Me	IF FEMALE:	23c If ve	s, outcome of pre	onancy		- In the last of the				CONTRACT	Para	
	ian	23b. Was decedent pregnant in the past 12 months?	10	Live birth 2 🗌 I	etal death 3	□Ectopic preg				23	3d. Date of de Month	elivery Day Year	
	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		Pregnant at time Unknown	ordeath 5	Other (spec	эпу)					,	
	Phy		litione appropriate	a to donth had and	reculting in the	underlying cause given in Part I. 23e. Did				tobacco use contribute to the cause of de			
	by										s 2 No 3 Probably 4 Onknown		
	ted	ノーシャ(たら	FIELLIT	05 171	72 11	HTRI	AL		10	185 2∐	1NO 3   1	TODAUTY 4 MOTIKNO	
	pje	FIBRILLATION	N'S						24a. Was		24b. Were a	autopsy findings availat completion of cause of	
									perfo	rmed2	death?		
	no.						26. F	Place of Dea	ath (Check only o	one)			
	3e Completed by Physician/Me	25. Was case referred to medi	ical		0 C C C C	ent 3 DOA	Other: 4	Nursing H	łome 5 ☐ Resi	dence 6	□Other (So	ecify)	
	o Be	25. Was case referred to mediexaminer?	Hospital:	1 Inpatient	Z L EN/Outpatie			DITT-DILL					
i	To Be	examiner? 1 Yes 2 No  27. Manner of Death	Hospital:	Date of Injury	28b. Time	of 280	c. Injury at		28d. Describe	how injury	occurred		
	To Be	examiner? 1	Hospital:	1 L Inpatient	28b. Time	of 280	c. Injury at Work? 1  Yes	2 🗆 No	28d. Describe	how injury	occurred		
	To Be	examiner?  1 Yes 2 No  27. Manne of Death  1 Natural 5 Pen  2 Accident inve  3 Suicide 6 Cou	Hospital: 28a. stigation	Date of Injury (Month, Day Yea	r) 28b. Time (Injury)	М	Work? 1 ☐ Yes	2 🗆 No	28f. Location (	Street and		Rural Route Number,	
o ale le	ertification; To Be	examiner?  1 Yes 2 No  27. Manne of Death  1 Natural 5 Pen  2 Accident inve  3 Suicide 6 Cou	Hospital: 28a. ding estigation ald not be	Date of Injury (Month, Day Yea	r) 28b. Time (Injury)	М	Work? 1 ☐ Yes	2 □No		Street and		Rural Route Number,	
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IIIIeu in by the juneral o	Certification; To Be	examiner?  1 Yes 2 No  27. Manne of Death  1 Natural 5 Pen  2 Accident inve  3 Suicide 6 Cou  4 Homicide	Hospital: 28a. stigation ild not be armined 28e. tying Physician: cal Examiner: On	Date of Injury (Month, Day Yea  Place of Injury - building, etc. (Sp.	28b. Time of Injury  At home, farm, specify)  knowledge, dea	M treet, factory, o	Work? 1 ☐ Yes office	te and place	28f. Location ( City or To	Street and wn, State) cause(s) a	Number or F	as stated.	
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	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manne of Death  1 Natural 5 Pen  2 Accident inve  3 Suicide 6 Cou  4 Homicide dete  29a. Certifier (Check only one)	Hospital: 28a. stigation lid not be armined 28e. tying Physician: cal Examiner: On and	Date of Injury - building, etc. (Sp.	28b. Time of Injury  At home, farm, specify)  knowledge, dea	M treet, factory, cath occurred at nvestigation, in 29c. t	Work? 1 ☐ Yes office the time, dat n my opinion,	te and place, death occu	28f. Location ( City or To	Street and wn, State) cause(s) a date and p	Number or F	as stated. ue to the cause(s) nth, Day, Year)	
	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manne of Death  1 Natural 5 Pen  2 Accident  3 Suicide 6 Cou  4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of cert	Hospital: 28a.  28a.  28b.  28b.  28c.	Date of Injury (Month, Day Yea Place of Injury - building, etc. (Sp.	28b. Time of Injury  At home, farm, siecify)  knowledge, dea nination and/or in	M treet, factory, cath occurred at nivestigation, in 29c. I	Work? 1 ☐ Yes office the time, date may opinion,	te and place, death occu	28f. Location ( City or To	Street and wn, State) cause(s) a date and p	Number or Fund manner ablace, and dusting signed (Months)	as stated. Le to the cause(s)  onth, Day, Year)  12 2806	
completely filled in by the funeral director, page 2 s	edical Certification; To Be	examiner?  1 Yes 2 No  27. Manne of Death  1 Natural 5 Pen  2 Accident inve  3 Suicide 6 Cou  4 Homicide dete  29a. Certifier (Check only one)	Hospital:  28a.  28a.  28b.  28b.  28c.  2	Place of Injury (Month, Day Yea  Place of Injury building, etc. (Sp  To the best of my the basis of exart manner stated.	28b. Time of Injury  At home, farm, specify)  knowledge, deanination and/or in	M Attreet, factory, of the occurred at nivestigation, in 29c. t	Work? 1 □ Yes office the time, dat n my opinion, License num	te and place, death occuber	28f. Location ( City or To	Street and wn, State) cause(s) a date and p	Number or F	as stated. ue to the cause(s) nth, Day, Year)	

Michelle D. Banks Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item# 23a,27,28a-f. pend (852,273) 06-00987 23a, 27, 28a-1, perME (352, 2723/06 TT State of Maryland / Department of Health and Mental Hygiene CTState Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Michelle D. Banks February 8 1:37 2006 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Good Samaritan Hospital N/A <u>Baltimore</u> 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 ☐ M 2 👿 F Yrs. Director 215-70-3485 43 Jul 8, 1962 Maryland Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits I7 ie marked other then "naturel", or Iteme 23e or 28e-f ahow treumatic event, I<u>ts Medical Examinar must be notified al</u> 1 XYes 2 No Director Maryland N/A **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5537 Cedonia Avenue 21206 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after of Hygiene.
I Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify Black 3 Widowed 4 Drivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Social Security Administration Secretary 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) . Pages 1 and 2 should be fit tment of Heelth and Mental H tant: if Item 27 is marked otl Be Earl Travers Dorothy Kyler ٥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Kyler Mother 5537 Cedonia Avenue Baltimore, Maryland 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State □Burial 2 □ Cremation 3 □ Removal from State Depertment of Important: If eny Injury or once. 02/08/06 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Western Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disfase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Mixed Drug Intoxication (Morphine, Cocaine, Tramadol) resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and s the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai ettending physical for use as the t IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the eld be detached for ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown should I Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? death? 2 No 2 No 1 Yes To the Hospital or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No ٩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA this tor: After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural r death. 1 ☐ Yes 2√TNo Fnd: 2/8/2006 Fnd 12:45 A 2 Accident unk 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5537 Cedonia Ave. within 24 hours efter d To the Funeral Direct completely filled in by 4 Homicide Baltimore, MD Found at residence 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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\*\*Commonstru 29a Certifier Medicai 29b. Signature and title of certifier 29c. License number -29d. Date signed (Month, Day, Year) 10 OCME February 8, 2006

State Registrar 31. Date filed (Month, Day, Year)
FEB 1 4 2006



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

		í	1 - ForAmend #11&12	2 Per State of	Maryland 6976 Ce	artment of H	lealth and M Death	ental Hygi Re	ene g. <b>2.</b> 006	04074
	ξΞ. I		1. Decedent's Name (First, Middle					2. Date of Death Month		3. Time of Death
	Physici /Medio		William	Russe	11	Berger			y 11,200	5.0
	Examir		4a. Facility Name (If not institution		per)	4b. City, Town, or	Location of Death		4c. County of D	Death
1 30	A	'S	1108 McHenry				Burnie If Under 24 Hrs.	0.0	Anne Ar	
	Funeral		5. Social Security Number 220-14-3326	6. Sex 7.	Age (In yrs. last birthday) 79 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Apr. 19,	Year) 9.	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	A				Apr. 19,	1920	MD
	show		10a. State 10b. County		10c. City, Town or Le	ocation				10d. Inside City Limits
	Mar Fied	ţo	MD Anne A	Arundel	Glen Burn	nie				1 ☐ Yes 2 ☐ No
	or 28	Oire	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wha	t Country?
	23a	rai	1108 McHenry Dr	cive		21061			USA	
	er de:	une	11. Marital Status	12. Was Deced	ent Ever in U.S. 13. es?	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe in, Mexican, Puerto I	cify Yes or No- Rican, etc.)		American Indian, Vhite, etc.
36	rs afte	by Funeral Director	1 Never Married 2 Married 3 Married 4 Divorced	If Van Cina		1 ☐ Yes 2X No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland sne. than "natural", or Items 23a or 28e-f show the Madical Examinal must be notified at	ba	15. Deceden	it's Education	16a, Dece	dent's Usual Occupa		1	6b. Kind of Busine	ess/Industry
215	Madin 72	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed)  College (1-4	life.	kind of work done of DO NOT use retired	during most of worki 1)	ng		,
21,	d with giene	mo.	12	0011090 (114	Inspe	ector			Fort Mea	ade
	2 should be filed withir and Mental Hygiene. Is marked other than surmatic event, the Ms	Be (	17. Father's Name (First, Middle,	Last)			18. Mother's Name	(First, Middle, M	faiden Sumame)	
Va	Ment de Marker	2	William H. Ber	ger				Richar		
Maryland	2 sho		19a. Informant's Name/Relations		1		and Number or Rura			. , ,
	ges 1 and 2 should be filed within 72 hours after death with the Maryla It of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or Items 23a or 28e-f show or other traumatic event, the Madical Exprimer must be notified at		Mrs Mildred Be	erger / Wif	e 1108 20b. Place of Dispe		rive Gler		MD. 210	
3altimore,	permit. Pages 1 and 2 Department of Health a Importent: If Item 27 Is any Injury or other tra <u>pnce</u> .		1 XBurial 2 Cremation		ate cemetery, cre	matory or other plac	Feb.	16		
Ξ	it. Partmer rtent rtent njury		4 □ Donation 5 □ Other (S 21. Signature of Funeral Service		Meadowrid	<del> </del>	200		lkridhe 1	
Ba	permit. Departr Importe any Inju		21. Signature of turneral service	Licensee	/					Home, P.A.
17			23a. Part1. Enter the disease, or	complications that cau	MO/3571					Approximate
	Dhysisian		shock, or heart failure. List Immediate Cause (Final	only one cause on eac	ch line.	1.				Interval Between
	Physician /Medical		disease or condition resulting in death)	a	as a consequence of):	eliona				J'mos
1	Examiner			1						
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of):					
	The law requires that the death certificate be executed ste has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	) c						
90,	se exe	ũ	sesuring in death, Last	Due to (or	as a consequence of):					1
8760	cate b	dical		d		<del></del>				
× 6	leath certific attending p	/Me	IF FEMALE:	23c If yes outco	ome of pregnancy				0010	
Box	atten for u	by Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birt	h 2 □ Fetal death 3[	□Ectopic pregnancy □ Other (specify)			23d. Date of Month	Day Year
P.O.	the d	iysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknow		Other (specify)				
	uires that the de signed by the a Id be detached f	y P	Part II. Other significant condition	ons contributing to dea	th but not resulting in the t	underlying cause give	en in Part I.	23e. Did tob	acco use contribut	te to the cause of death?
Records,	quires n sign	d b						1 <b>⊠</b> Ye	s 2□No 3□	Probably 4 Unknown
00	s been should	jete						24a. Was an	24b. Wer	e autopsy findings available to completion of cause of
Re	The lav	Completed						autopsy perform	/ prior led? deat ☑No 1 ☐	h?
ital		Be C	25. Was case referred to medica	1			26. Place of Death			103 225,110
of Vital	Physicien: this certific ral director,	Tof	examiner? 1 ☐ Yes 2 No	Hospital:	patient 2 ER/Outpatie	nt 3 DOA	er: 4 Nursing Hor	ne 5 Reside	nce 6 Other (	Specify)
0	ding Pt n. After th funeral		27. Manner of Death  Natural 5 ☐ Pendir	28a. Date of (Month,	Injury 28b. Time of Day Year) Injury	of 28c. Injury World	y at k?	28d. Describe ho	w injury occurred	
Sio	ttendi death. ctor: A y the fu	cati	2 Accident investi	gation not be			Yes 2 □No			
Division	or Attending after death. Director; After in by the fune	Certification;	4 Homicide determ	289. Place o	f Injury - At home, farm, st j, etc. <i>(Specify)</i>	reet, factory, office		28f. Location (Str City or Town	eet and Number o , State)	r Rural Route Number,
	pitel ours a erel [		29a. Certifier 12. Certifyir	ng Physisian, T. 45-5	act of my knowledge de-	th annured at the t	no date and the	and due to the		r on stated
	To the Hospitel or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	(Check only 2 Medical one)	Exeminer: On the bas and manne	est of my knowledge, deat is of examination and/or in r stated.	nvestigation, in my o	pinion, death occurr	ed at the time, da	use(s) and manne ite and place, and	due to the cause(s)
	Fo the	Me	29b. Signature and title of certifie		1	29c. Licensi	e number	29	d. Date signed (N	Ionth, Dey, Year)
			Non	11/1/2	1	13	ハイン	1	15 in a	13 7001
	(n V		ame and address of person	who completed cause	of death (Item 23a) (Type	Print)	/	7-7	MI arang	1, 1000
	W		Kussell R. De	(lea, 1.D-	305 Hass	ital Or	1Ve, 6-/	a Bur	Linay	2106/
Life	Sta		31. Date filed (Month, Day, Year)	2006 32 Aeg	gistrar's Signature	200				
J2.X	Regist	ar	1 1 1 1	LUUU RIGHT	1582 1 B	SA				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Eva Theresa Brizendine February 10 2006 10:50A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 90 1 M 2 F Yrs. Director 215-09-2106 December 27,1915 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Department of Heatih and Mental Hygiene. important: if item 27 is marked other than "natural; or iteme 23e or 28e-f ehor any injury or other traumetic event, I'ta Medical Examinar must be notified at Maryland | **Baltimore** 1 Yes X No Lochearn Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3835 Arbutus Avenue 21207 United States of America 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Defense Elementary/Secondary (0-12) College (1-4or 5+) Aeronautical Assembly 7th Glen L. Martin Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Walter Holland Dora Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3835 Arbutus Avenue, Lochearn, Maryland 21207
Date 20c. Location - City or Town, State Donald N. Brizendine (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Lake View Memorial Pk 02/14/06 Sykesville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Loring Byers Funeral Directors, Inc 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) OCCUSION, COMPLETE, LEFT LEG **Physician** /Medical Examiner ascular disease phera Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transil Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day 4□Pregnant at time of death signed by the all be deteched for 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by FIBRILLATION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Jnknown this certificate has been sl at director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No 1 Yes 2 No 1 Yes 3ri zerdine. funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification; To 27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospitel within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completaly (Check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D25643 10 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) taulener MD/6601 N. Chaules Steet/Bolto MD 3 Registrar's Signature State Registrar

2006

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 Month **Physician** 16:08 MHOL FEBRUARY 10 BARNES /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A UNIVERSITY OF MARYLAND MEDICAL BALTIMORE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 6. Sex 12 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Yrs Director Feb. 02,1934 219-30-0109 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-1 show the Medical Examiner must be notified at Marvland Pasadena 1 ☐ Yes 2 No Anne Arundel Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21122 U.S.A. 70 Beacrane Road or itsms 23a filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Preston other than Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be fill ment of Health and Mental H snt: if item 27 is marked oth James E. Barnes Lilly M. Muir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Johanna I Barnes (Wife) 70 Beacrane Road, Pasadena, Maryland 21122 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Burnie Maryland permit. Page Department of importent: if any injury or once. 4 □ Donation 5 □ Other (Specify) Glen Haven Mem Park 02-14-06 21. Signature of Fun entire Licenses McCully-Polyniak Funeral Home P.A. 3204 Mountain Koad, Pasadena, Maryland 21122 un > 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ususe on each line. Approximate Interval Between disease or condition resulting in death) Onset and Death Physician RIGHT MIDDLE CEREBRAL ARTERY DAYS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inflated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ate has been signed by the attending physicien page 2 should be detached for use as the buria by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? HYPERTENSION 1 ☐ Yes 2 ☑ No 3 Probably 4 Dunknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 140 ATRIAL FIBRILLATION 24a Was an this certificate 1 Yes 2 No the funeral director. 25. Was case referred to medical 26. Place of Death | Check only one examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 DNo 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t or Attending 1 Natural 5 Pending Injury deeth. 1 ☐ Yes 2 ☐ No 2 Accident investigation Director: 3 Suicide 6 Could not be determined 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ML FEB, 10,2006 18564 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNIVERSITY OF MARYLAND MEDICAL CENTER, BAITIMOS ARPENTER UN 2006 32 Agistrar's Signature MACKENZIE State Registrar

Please Type or Print in Black indelible Ink. Ensure All Copies Are Legible.

Amend item#27,29a,29c, perfly, 6852,2/14/06 IT

State of Maryland Department of Health and Mental Hygiene

Tob

Certificate of Death

Beg. No. 11 15

Can To

4b. City, Town, or Location of Death

1. Decedent's Name (First, Middle, Last)

4a. Facility Name (If not institution,

niversity

Physician

/Medical

Examiner

1. Ften

give street and number)

2. Date of Death

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N/A

4c. County of Death

25

DHMH 17 Rev 1/200

Registrar

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			For State Registrar	State of Marylan		artment of rtificate of		Mental Hy	giene Reg. No 2006	04078
	Physicia		1. Decedent's Name (First, Middle, Last)  Gordon F.	Benner				2. Date of De Month	Day Yeer	
	/Medica Examine		4a. Facility Name (If not institution, give			4b. City, Town,	or Location of Dea		4c. County of De	
	Funeral		Franklin Square 5. Social Security Number 6. Sec			ROS If Under 1 Yea Months Days		(Month, Da	Balt th ay, Year) 9. B	inthplace (State or Foreign
	Director		216-12-7091 Suel Residence of Decedent	81 81	Yrs.		,	April	28,1924 N	MAryland
	/land	ŀ	10a. State 10b. County	10c. City	, Town or L	ocation				10d. Inside City Limits
	a-f eh	ţŏ	MD Balti	.more	Whi	te MArs	h			1 ☐ Yes 2 XNo
	or 28	Öire	10e. Street and Number			10f. Zip Code			10g. Citizen of What 0	Country?
	• 23s	rai	11013 Red Lion	Road  12. Was Decedent Ever in U.	6 12	211		Pagaity Van as Na	USA	nerican Indian.
38	should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other then 'natural', or iteme 23s or 28s-f show matte event, the Modical Examinar must be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ XWidowed 4 ☐ Divorced	Armed Forces?  1 Types 2 □ No If Yes, Give Year or Dates:	3.	1 ☐ Yes 2 ☑ No	Hispanic Origin? (: ban, Mexican, Pue Specify:	to Rican, etc.)	Black, Wh	ite, etc.
Sp.	72 hou	ted	15. Decedent's Edu (Specify only highest grad		16a. Dece	edent's Usual Occu	apation	orkina	16b. Kind of Busines	
27.5	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			e during most of wo		U.S.Gove	ernment
42	filed w Hygier ther ti		10th 17. Father's Name (First, Middle, Last)		ware	enouse	Supervi:		, Maiden Sumame)	
Maryland 27215	ould be I Mental I arked o	To Be	George Lynch					Engle	,,	
	s 1 and 2 should f Health and Men flem 27 ie marke other traumatic	-	19a. Informant's Name/Relationship (Ty	rpe, Print)	19b. Mail	ing Address (Stree			er, City or Town, State	Zip Code)
Z.	and 2 ealth a n 27 i		Tina Manley /da				Lion Roa		e MArsh N	
Benn Baltimore,	0 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	temoval from State	emetery, cre	osition (Name of ematory or other pl sofFait		Date 17/06	20c. Location - City of Rossvill	
Balt	permit. Pag Department Important: eny injury o		21. Signature of Funerel Service Licens	Counelle	1/2	2. Name and Add		Connell;	yFuneralH more MD 2	omeofEssex
	Physician /Medical Examiner   Physician and physician and	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Respirations that caused the deather cause on each line.  Respiration of the deather cause on each line.  Due to (or as a consequence of the conse	uence of):	Failt	ring, such as cardia	ac or respiratory a	rrest,	Approximate Interval Between Onset and Death
P.O. Box 68760,	E C S	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	death 3	□Ectopic pregnan □ Other (specify)	су		23d. Date of d Month	elivery Day Year
	uires that signed b	<u>۾</u>	Part II. Dther significant conditions con	ntributing to death but not resu	ulting in the o	underlying cause g	iven in Part I.		tobacco use contribute Yes 2 No 3 □ I	to the cause of death?  Probably 4 Unknown
∆ Division of Vital Records,	Physicien: The law requir this certificate has been si ral director, page 2 should	Completed						24a. Was auto perfo 1 ☐ Yes		
Vit	sicien certif rector	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1 Inpatient 2	CD/O		than	ath (Check only		
on of	iding Physics.  After this funeral di	⊢ չ	27. Manner of Death  1 Manual 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of 28c. Inj	4 Nursing		idence 6 Other (Sp how injury occurred	өсігу)
Divisi	al or Attendi s after death. I Director: A d in by the fu	Certification	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, si	treet, factory, office	3		'Street and Number or i wn, State)	Rural Route Number,
6		Medicai C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wledge, dea tion and/or i	th occurred at the nvestigation, in my	time, date and place opinion, death occ	e, and due to the curred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
9	To th withir To th comp	ž	29b. Signature and title of certifier	facili mo			se number	,	29d. Date signed (Mo	
			30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Type	, Print)				
	Stat	_	Maurice Saa 31. Date filed (Month, Day, Year)	h, MD, GUDO 32. Regiŝtrar's Signa	Eran.	Klin Squ	are Drive	-, Balti	2/10/06 more, 14]	21237
	Registra	:1	FFR 1 4 2	NAG Printer of	13. A	September 1				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Helen Frances Buchanan **Physician** February 11, 2006 12:00 P.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF 83 Yrs 28, 214 18 1644 1922 North Carolina Director Usual Residence of Decedent the Manyland 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show item 27 is marked other than "naturel", or iteme 23a or 28a-f show other traumatic event, the Mardical Expandrant must be notified as Maryland 1 ☐ Yes 2 No Anne Arundel Arnold Directo 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S. 433 Shore Acres Road Apt. 2B 21012 Funerai deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cook Gunnings Restaurant 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be if Health and Mental Martha Murphy Iron Cauiness ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Patricia Morning / Daughter 433 Shore Acres Road Apt. 2B Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition permit. Peges 'Department of H Importent: If ite eny injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☑ Other (Specify) Entombment Cedar, Hill Cemetery 2/14/2006 Baltimore, Maryland 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee manucala 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part . Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (or as a consequence of) disease or condition resulting in death) /Medical Lung Prieme Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a conseque Examine burial-transit The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Box 68760. the attending physicien Completed by Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day ŏ Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) Yes 2 No Q 9□ Unknown 9 Unknown Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy this certificate 1 Yes 2 No Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Tyes 2 No 1- Impatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural 5 Pending investigation 1 Tyes 2 No 2 Accident 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year, 29b. Signature and title of certifier 10057635 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) medic of 32. Registrar's Stanature State Registrar

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Division of Vital Records, P.O. Box 68/60,	Hospital or Attending Physicien: The law requires that the death certificate be executed a house after along	Farnous area forcing.  Farnous area forces. After this certificete has been signed by the attending physicien and intended for the functal director base 2 should be detached for use as the burial-transit.

		1 - For State Registrar	State of Maryland / D	epartment of H Certificate of L			ene g. No. 006	04081
∗ Physic		1. Decedent's Name (First, Middle, Last)  BETTY BE	LICKMAN			2. Date of Death Month FEBRUA	Day Yeer	3. Time of Death 4: 50 P M
/Med Exam		4a. Fecility Name (If not institution, give st	reet and number)	4b. City, Town, or	Location of Death		4c. County of Death	nore
Funera Directo		0.0 20 020 .	M 2 F 7. Age (In yrs. last bint	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 10/03/19	9. Birth 25	place (State or Foreign Intry) NEW YORK
land w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			- 1	10d. Inside City Limits
Marylan a-f show	ctor	MD BALTIMORE	BALTIM	10RE				1 ☐ Yes 2 🕅 No
th with the	Funeral Director	10e. Street and Number 904 BITTERSWEET R	ROAD	10f. Zip Code 21208		10	lg. Citizen of What Co. U.S.A.	intry?
be filed within 72 hours after death with the Maryland tal Hygiene. I dother then "neture!, or Items 23a or 28a-f show event, the Moulcal Examinar court be notified at	þ	11. Marital Status 1:  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
72 hc	eted	15. Decedent's Educa (Specify only highest grade	completed)	Decedent's Usual Occupa (Give kind of work done of life. DO NOT use retired	furing most of workir	ng 1	6b. Kind of Business/I	ndustry
s 1 and 2 should be filed within 72 hd if Health and Mental Hygiene. Item 27 is marked other then "netur other traumatic event, the Madical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	INISTRATIVE		Γ	TIME CLOCK	S
be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		DD ON 7	18. Mother's Name	(First, Middle, M		WDED
should nd Men	2	MAX  19a, Informant's Name/Relationship (Typ	e, <i>Print</i> ) 19b.	BRONZ Mailing Address (Street a	ANNA and Number or Rura	l Route Number,	COMM/	
and 2 : ealth ar n 27 is		BONNIE GREENWALD	/ DAUGHTER 6	SHELTON COU	RT REIST	ERSTOWN	, MD 21136	
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other frai		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State cemeters	Disposition (Name of c crematory or other place YOUNG MENS	θ)		NOODLAWN, N	
Departit. Departit		21. Signature of Funeral Service Licenser	7	22. Name and Addres	30		SON & BROS PIKESVILLE	
		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do not cause on each line.					Approximate Interval Between
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uted	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequence o	1):				
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To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  To the Funce Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	clan/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	ic. If yes, outcome of pregnancy	3 ☐ Ectopic pregnancy			23d. Date of deli	very Day Year
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ortifice ctor, p	BeC	25. Was case referred to medical examiner?			26. Place of Death			2 (28) 140
Physic this ce	၉	1 Yes 2 No	ospital: 1 Inpatient 2 ER/Out 28a. Date of Injury 28b. T	patient 3 DOA Other	4   Nursing Hor		nce 6 Other (Spec	ıfy)
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To the Hospital or within 24 hours after To the Funeral Direction of the Completely filled in	edical (		ician: To the best of my knowledge, er: On the basis of examination and and manner stated.					
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5		30. Name and address of person who cor NORTH WEST +CO	SPITAL SHOLOL	COURT RO	SAD RAN	DALLSTO	שט אש	21133
S Regis	tate	31. Date filed (Month, Day, Year)	32. Registrar's Signature	Long.				
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		Please Type or Print in Black Indelible Ink. Ensure All	Copies Are	Legible.
		State of Maryland / Department of Health and Me  State Certificate of Death	ntal Hygiene Reg. Ne	THE HEIRZ
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/Med Exam		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  SINA' HOSPITAL OF BALTIMORE CIT	Y 40	c. County of Death
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Months Days Hours Min.	3. Date of Birth (Month, Day, Year, 19/07/1924	
aryland •how	٥	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  Baltimore		10d. Inside City Limits 1 □ Yes 2 □ No
n the N r 28a-1	rect	Maryland   10f. Zip Code	10g. C	itizen of What Country?
th with	a D	1150 Shields Place 21201		J.S.A.
36 s after dea , or Itema	by Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ring Yes, Green Status)  14. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ring Yes, Green Status)  15. Was Decedent Ever in U.S. Armed Forces?  16. Was Decedent of Hispanic Origin? (Specific Yes, specify Cuban, Mexican, Puerto Ring Yes, Green Status)  17. Was Decedent Ever in U.S. Armed Forces?  18. Was Decedent of Hispanic Origin? (Specific Yes) Provided Hispanic Origin? (Specific Yes	ify Yes or No- ican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: Black
Nore, Maryland 21215-0036 ges 1 and 2 should be filed within 72 hours after death with the Maryland at of Health and Mental Rygiene. If item 27 is marked other then "natural", or Itema 23s or 28s-1 show or other traumatic event, the Medical Examinar must be notified at	Completed b	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. h	Kind of Business/Industry
aryland 212 should be filed within and Mental Hygiene.  • marked other ther unatic event, the market	Be Com	Elementary/Secondary (0·12) College (1-4or 5+)  12 Inventory Specialist  17. Father's Name (First, Middle, Last)  18. Mother's Name (6.1)	(First, Middle, Maide	Retail n Sumame)
rlan	To B	Joseph Scotland Gertrude	Cutting	
Maryland 4 2 should be file th and Mental Hy 77 Is marked oth traumatic event		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural II		
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Baltim permit. Pa Departmen Important any injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility ['he ] 4611 Park Hgts. Ave.		
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To the Hospital within 24 hours a To the Funeral I completely filled	Medical	29a) Certifier  (Check only one)  2   Medical Examiner: On the bast of my knowledge, death occurred at the time, date and place, at (Check only one)  2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurre and manner stated.  29b. Signature and title of certifier  29c. License number	ed at the time, date a	ond place, and due to the cause(s)  Date signed (Month, Day, Year)
10 V		29b. Signature and title of germany		BRUARY 13th 2006
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SiNAi HOSP		2006
		PAUL AOUN, D.O., Ph.D.		
	State	31. Date filed (Month, Day, Year)  Separation of the filed (Month, Day, Year)  32. Pegistrar's Signature		
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		•	For State Registrar			Cer	tificate of	Death	Reg	3. No. UUD	04000
-	Physicia	an	Decedent's Name (First, Middle, La.						2. Date of Death Month	Day Year	3. Time of Death
	/Medic		Michael Anthony				4h City Town o	r Location of Death	FEBRUARY	7, 2006 4c. County of Deatl	1030 P
	Examin	er	4a. Facility Name (If not institution, gives SOUTH SALISBURY		ODS)		SALISBUR			WICOMICO	
	Funeral		5. Social Security Number 6. S	Sex 7. Age	e (In yrs. last b	oirthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 27,		nplace (State or Foreign untry)
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2	pue *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation				10d. Inside City Limits
	Maryli f sho	tor	Maryland Wicomic	0	Sa	alish	oury				1 ☐ Yes 27 No
	r 28a	Director	10e. Street and Number				10f. Zip Code		10	g. Citizen of What Co	untry?
	th with	ai D	628 Smith Stree	t Apt. B			218			USA	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23a or 28a-f show amy fujury or other traumatic event, I'm Medical Exam har must be notified at ODGe.	by Funeral	11. Marital Status	12. Was Decedent Armed Forces?  1 XYes 2 1 1 Yes, Give Year or Dates:			Vas Decedent of H f Yes, specify Cub I ☐ Yes 2 XNo		specify Yes or No- to Rican, etc.)	14. Race - Ame Black, White Specify: W	
8	ture!	edt	15. Decedent's E	ducation		ia. Dece	ient's Usual Occup	pation	etrin =	6b. Kind of Business/	Industry
Baltimore, Maryland 21215-0036	vithin 72 ne. hen "ne e Wedik	Completed	(Specify only highest gr.	ade completed) College (1-4or 5	5+)	life.	kind of work done DO NOT use retire nemployed		rking	N/A	
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Σ	and 2 salth a n 27 i		Debra Morrison,	Sister					Pasadena	Maryland Oc. Location - City or	21122
ore	Titer Fiter or oth		20a. Method of Disposition 1 ☐ Burial 2 ②Cremation 3	Removal from State			sition (Name of natory or other pla				
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Bal	Department of the poor of the		21. Signature of Funeral Service Lice Thomas Gregor	Dry		-	Cremation	n Society	/Of Mary. ad Baltimo	land Inc. ore, Maryl	and 21228
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Division of Vital Records, P.O.	The law re- te has bee age 2 sho	ompiet							24a. Was an autops perform	y prior to ned? death?	utopsy findings available completion of cause of s 2 No
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	he Hospital or Attendi n 24 hours after death. he Funeral Director: A pletely filled in by the fo	edicai C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner s	of examination	dge, dea and/or i	th occurred at the nvestigation, in my	time, date and plac opinion, death occ	ce, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
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	Examin		4a. Facility Name (If not in	В		rs Hospita					timore			N/A
3	Funeral Director		5. Social Security Number 241-44-985	1 1	өх □м 2□ <b>х</b> F	7. Age (In y	rs. last birthda 80 Yrs.	Month	ler 1 Year s Days	If Under 24 Hrs. Hours Min.	(Month, L	irth Pay, Year) 10, 1925		nplace (State or Foreign untry) Io. Carolina
faryland	show	or	Usual Residence of Deceding 10a. State 10b.  Maryland	County	N/A	10c.	City, Town or	Location	B	altimore				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the N	3a or 28a-	al Director	10e. Street and Number 1007 North Mo					10f. 2	Zip Code	21217		10g. Citizen o	of What Cou	•
filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "naturel", or Items 23a or 28a-f show ery injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral I	11. Marital Status  1 Never Married 2 3 Widowed 4 D		Armed I	2 □XNo Sive	U.S. 1:		cedent of Hi becify Cuba 2 1100	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No Rican, etc.)	14. R B	lack, White	ican Indian, , etc. <b>Black</b>
d within 72 ho	jene. r then "natur I're Medical	Completed	15. D (Specify only Elementary/Secondary		ide completed	(1-4or 5+)	16a. De	cedent's Usive kind of the NOT		ation furing most of wor se's Aide	rking	16b. Kind of		ndustry g Home
id be filed	fental Hyg rked othe ilc event,	To Be C	17. Father's Name (First, )		McCoy					18. Mother's Nan		e, <i>Maiden Sum</i> R <b>ena McC</b>		
nd 2 shou	27 is main 27 is main or traumai	-	19a. Informant's Name/Re Janice Gross I				19b. Ma	_		and Number or Rul				p Code)
Pages 1 a	nent of Her ant: If Item ury or othe		20a. Method of Disposition 1 □ Meurial 2 □ Cren 4 □ Donation 5 □ C	nation 3			Place of Discometery, of Garrison	rematory o	r other place	s Cemetery	Date 02/10/06	20c. Locatio		Town, State Mills, Md.
permit.	Departe Imports eny in		21. Signature of Funeral S	Service Licer	25 es	top		22. Name	Esten B	s of Facility Brothers Fun- utaw Place B	eral Servic	e, P. A. Vid 21217		
1	physician and Medical kaminer s the burial-transit	edical Examiner	23a. Part1. Enter the dise shock, or heart failured in the cause (Final disease or condition resulting in death)  Sequentially list condition if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	(	b. Val	o (or as a cons	equence of):  Heart equence of):  Herter	· 0:	i ever	PATHY				Interval Between Onset and Death Sym.
To the Hospital or Attending Physicien: The law requires then the death certif	I by the attending latached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnin the past 12 month 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live	utcome of predictions	etal death	3 □Ectopic 5 □ Other	pregnancy (specify)				Date of deliv	very Day Year
quires thet t	been signed by should be deta	þ	Part II. Other significant of	conditions o	ontributing to	death but not i	esulting in the	underlying	g cause give	en in Part I.		tobacco use co	/	the cause of death?
The lawre	cete has bee	Completed									24a. We aut per 1 🗆 Yes	opsy formed?	b. Were autoprior to condeath?	opsy findings available ompletion of cause of
ysicien	this certificete har al director, page 2	To Be	25. Was case referred to examiner?  1 Yes 2 Ho	medical	Hospital:	Inpatient 2	ER/Outpat	ient 3 🗆	DOA Othe	26. Place of Dea		one)	Other (Speci	ıf <b>v</b> )
Attending Ph	within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	ertlflcation:	2 Accident 3 Suicide 6	Pending investigation	(Mo	e of Injury onth, Day Year, ce of Injury - A		М		at ?? Yes 2 □ No		how injury occ		ral Route Number,
spital or	nours after nsral Dire	O	4 ☐ Homicide  29a. Certifier 1 ☐ €	determined ertifying Ph	buil	ding, etc. (Spe	cify)  nowledge, de	ath occurre	ed at the tim	e, date and place	City or T	own, State)	manner as:	stated.
the Ho	thin 24 to the Fu	Medical	(Check only 2 Mone)  29b. Signature and title of		niner: On the and ma	basis of exam unner stated.	ination and/or		on, in my op	pinion, death occu	irred at the time	, date and place 29d. Date sign		
Ť	¥ 1 8		May	1/1/	ch_	-m				2372			/200	
	4		30. Name and address of 2000 West		-, more	use of death (I	tem 23a) (Typ	e, Print)	, no	21223				
	Sta Registr		31. Date filed (Month, Day	1 4 20	106	Registrar's Sig	gnature	with .	)					

DHMH 17 Rev 1/2001

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For	artment of Health and Mental Hy <i>rtificate of Death</i>	giene Reg. Ng. 006 04085
			Decedent's Name (First, Middle, Last)	2. Date of D	Day Year
	Physicia /Medic	al	Rutus	Carwell Februar	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Johns Hopkins Bayu ew Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Baltimore  If Under 1 Year   If Under 24 Hrs.   8. Date of Bi	irth 9. Birthplace (State or Foreign
	Funeral Director		213-32-5115 18M 2 F 68 Yrs.	Months Days Hours Min. (Month, D	i, 1937 MARYLAND
	ס	1	Usual Residence of Decedent		
	anylan show		Maryland M/A Balti		10d. Inside City Limits 1.☑Yes 2 ☐ No
	8a-f	Director		10f. Zip Code	10g. Citizen of What Country?
	with t	5	539 Na- Pittsbury Ave	21222	United States
	heath ne 23	Funeral		Was Decedent of Hispanic Origin? (Specify Yes or N ff Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
36	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland arment of Health and Mental Hyglene. ortant: If item 27 is marked other than "natural", or itema 23s or 28s-f show injury or other traumatic event, the Medical Exeminar must be notified at injury or other traumatic event, the Medical Exeminar must be notified at .	by Fur	Armed Forces?  1 Never Married 2 Married 1 Neves 2 No If Yes, Give  3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 No Specify:	Black, White, etc.  Specify: Black
21215-0036	2 hou atura cal E	ted	15. Decedent's Education 16a. Dece	edent's Usuaf Occupation a kind of work done during most of working	16b. Kind of Business/Industry
215	e. en n	Completed	life.	DO NOT use ratired) !	Art Litho Co.
7	ygien ygien ver th	S		18. Mother's Name (First, Middl	
Maryland	d be fil	То Ве	17. Father's Name (First, Middle, Last) Rufus E, Carwell		wKins
ary.	shoul nd Me marl	F		ing Address (Street and Number or Rural Route Num	ber, City or Town, State, Zip Code)
	and 2 salth a n 27 is		Mary Carwell - Wise 530	and the same of th	Baltimore, MD 21222
altimore,	of He of He if Item		20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State		20c. Location - City or Town, State
Ë	Pag tment tant:		4 Donation 5 Other (Specify) Carrison	Formest V.A. Feb 17,2006	Charles really
Ball	permit. Pages Department of h important: if its eny injury or of		21. Signature of Funeral Service Licensee	22. Name and Address of Facility LIAMS PO. Box 1165/ Bultin	one MD 21229
			23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
N.	Pnysician		Immediate Cause (Final disease or condition a. Septimental Septime		
1	/Medical Examiner		Due to (or as a consequence of):		
		ē	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):		
	uted d ansit		cause. Enter Underlying Cause (Disease or injury that initiated events  c		1
oʻ	cate be executed physicien and the burial-transit	Exam	resulting in death) Last  Due to (or as a consequence of):		
8760	cate be physicial the bu	dical	d		
9		Med	IF FEMALE:		and Date of delivery
Вох	eath certific attending p for use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
o.	by the detached	ysic	1 Yes 2 No 9 Unknown	Cities (specify)	
<u>α</u>	£ 20 €	by Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
rds	w requires been sign should be		End Stage Renal disease	1	Yes 2 No 3 Probably 4 Unknown
Records,	law requass been	Completed	Congestive Heart Failure	24a. We	as an 24b. Were autopsy findings available prior to completion of cause of
Ä	The I	ĕ	Diabetes Mellitus	per 1 ☐ Yes	nomed2 death? 1 ☐ Yes 2 ☐ No
Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Check only	one)
of \	Physician: this certific ral director,	၉	1 Tes No Hospital: Impatient 2 ER/Outpatient 27. Manner of Death 28a. Date of Injury 28b. Time		sidence 6 Other (Specify) e how injury occurred
UC C		lon	i Natural 5 ☐ Pending (Month, Day Year) Infury		o now injury coostinue
Division	leat for: the	ficat	3 Suicide 6 Could not be 28e. Place of fnjury - At home, farm, s	street, factory, office 28f. Location	(Street and Number or Rural Route Number,
Ö	ੂੰ ਜੂੰ ਵ	Certification:	4 Homicide determined building, etc. (Specify)	City or I	own, State)
1	I 4 I 0	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal of the deal o		
	within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	F > F 0		Malahao 1 tole Mil	RES-001	February 13, 2006
-			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	
			Michael Polo 4940 Eastern Aver	RES-001 nue, Baltimore, Mary	land, 21224
3/5	St Regist	ate	31. Date filed (Month, Day, Year)  FFR 1 4 2006	rate x	

CPM 06-01009 Richard Clary

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	,	1	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of H rtificate of L			g. No. O	5 040	86
	Physicia		1. Decedent's Name (First, Middle, Last		0.			2. Date of Death Month	Day	3. Time	
	/Medic	al	Kich  4a. Facility Name (If not institution, give	ard Eugen	e Clary	4h City Town or	Location of Death	February	7 08, 2	2006 20:2	25
7	Examin	-	3939 Roland Avenue		t 918		ltimore			N/A	
	Funeral Director		5. Social Security Number 6. Se 216-34-9159		69 Yrs.		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 7,	1936	9. Birthplace <i>(State</i> <i>Country)</i> Georgia	or Foreign
	and **	}	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside	City Limits
	Mary First	to	Maryland N	/A	Balt	imore				1 🗓 🗶	s 2 No
	or 28s	Sirec	10e. Street and Number			10f. Zip Code	01011		g. Citizen of Wi	-	
	e 23s	erall	3939 Roland Avenue	Apt. 9		Was Decedent of Hi	21211		14. Race	USA - American Indian,	
21215-0036	n 72 hours after death with the Maryland "natural; or Iteme 23a or 28a-f ehow salical Examinat must be notified at	by Funeral Director	11. Marital Status  1XXNever Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2X XI If Yes, Give Year or Dates:	1959–61	Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes <b>XX</b> No	Specify:		Specify:	, White, etc. white	
2-0		etec	15. Decedent's Ed (Specify only highest grad	ucation fe com <i>pleted)</i>	16a. Dece (Give	dent's Usual Occupa kind of work done of DO NOT use retired	ation during most of work	sing 1	16b. Kind of Bus	iness/Industry	
121	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	4)	rical wor			Marylan	d Casual	ty Ins
	be filed tal Hygi d other	Be C	17. Father's Name (First, Middle, Last)				_	e (First, Middle, M		)	
ylar	should be filed within a Mental Hygiene. marked other then matte event, tre his	2	Curtis Eugene Cla					Lura Todd		21- 21- 21- 21- 11- 11- 11- 11- 11- 11-	
Maryland	ind 2 sho alth and 27 le m or treum		19a. Informant's Name/Relationship (7 Peggy Thompson	урө, Print) Sist		ing Address <i>(Str</i> eet a		_	ore, MI		
	s 1 and 2 should be filed within f Health and Mental Hygiene. Item 27 le marked other then other treumatic event, the Mental contractions.		20a. Method of Disposition			osition (Name of ematory or other place				City or Town, State	
OE .	Pages nent of int: If I		1 ☐ Burial 2 ☐ Cremation 3X☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State )	Ebeneezer	Baptist	Church Ce	em. G1	lennvill	e, Georg	ia
Baltimore,	permit. Pages 1 an Department of Heal Important: If Item 2 eny Injury or other once.	4 Donation 5 Other (Specify)  21. Signature is neral Service Licensee  22. Name and Address of Facility  Burgee-Henss-Seitz Funeral Home, Inc.  36.31 Follow Road Boltimare Maryland, 21.21								nc.	
Burgee-Henss-Seitz Funeral 3631 Falls Road Baltimore shock, or heart failure. List only one cause on each line.  Physician (Medical  Burgee-Henss-Seitz Funeral 3631 Falls Road Baltimore. Shock, or heart failure. List only one cause on each line.  Due to (or as a consequence of):							or respiratory arre	est,	Approxim Interval B Onset an	etween	
	Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	a consequence of):						
68760,	icate be executed physicien and s the burial-transit	edical Ex	resulting in doutin, cast	d.	a consequence or).						
P.O. Box 6	Attending Physicien: The law requires thet the death certific death. ctor: After this certificate has been signed by the attending p y the funeral director, page 2 should be detached for use as y	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify) _	,		23d. Date Mon	of delivery th Day	Year
	uires thet n signed b id be deta	ρ	Part II. Other significant conditions of	ontributing to death t	out not resulting in the	underlying cause giv	en in Part I.			bute to the cause of	uf death? Unknown
of Vital Records,	The law requir ate has been si page 2 should	Completed	V					24a. Was all autops perform	y ned? d	Vere autopsy finding rior to completion of eath?	s avaitable cause of
ital	ician: ] certifica rector, p	Be	25. Was case referred to medical examiner?					th (Check only on	21		
> <	Physic this ce al direi	မ	No 2 □ No		ent 2 ER/Outpati		4   Nuising n	ome 5 Reside		or (Specify) SCE	NE
uo	ding F h. After funer	tlon	27. Manner of Death  12 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inj. (Month, Da	y Year) Injury	Wor	k? Yes 2 □ No	200. 5000.150	,,	-5	
Division	ت <del>ا</del> الله و	Certification:	3 Suicide 6 Could not by determined	28e. Place of In	jury - At home, farm, stc. (Specify)	street, factory, offica		28f. Location (St City or Town	reet and Number, State)	ar or Rural Route N	umber,
	Hospitel     24 hours     Funeral I     etely filled	Medical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best niner: On the basis of and manner s	of my knowledge, de of examination and/or tated.	ath occurred at the ti investigation, in my c	me, date and place prinion, death occu	and due to the carried at the time, d	ause(s) and mai ate and place, a	nner as stated. and due to the caus	e(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	. 0.		29c. Licens			-	(Month, Day, Year	
			Theody 1	1. King.	(in	0.	C.M.E.		February	y 09, 200	6
	3		30. Name and address of person who	7 1	111	e, Print) L Penn Str	reet, Bal	timore, l	Maryland	1 21201	
	St Regist	ate rar									

			1- State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 6 0 4 0 8 7
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Olson G Crouse  2. Date of Death Month Day Year 5:35 PM
	Examin		4a. Facility Name (If not institution, give street and number)  Baltimore Washington Medical Center  4b. City, Town, or Location of Death  Glen Burnie  4c. County of Death  Anne Arundel
	Funeral Director		5. Social Security Number 225 32 4046  6. Sex 75 Yrs.  7. Age (In yrs. last birthday) 75 Yrs.  1
	Maryland -f ehow	tor	Usual Residence of Decedent  10a. State
	h with the	ai Director	10e. Street and Number 6801 Rapid Water Way Unit 104 10f. Zip Code 21060 10g. Citizen of What Country? U.S.
036	permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene Important: if item 27 is marked other then "natural, or iteme 23a or 28a-f ehow appringing or other treumatic event, I'm Medical Examinal must be notified at once.	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Mo If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  1 Yes 2 No Specify: White
Maryland 21215-0036	within 72 ho lene. then "natur the Medical.	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) 12th  15a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Salesman  16b. Kind of Business/Industry F.A. Davis & Son Wholesale Company
land 2	uld be filed dental Hyg rked other tic event,	To Be C	17. Father's Name (First, Middle, Last)  Garrett H. Crouse  18. Mother's Name (First, Middle, Maiden Sumame)  Hettie Baker
, Mary	and 2 shores and A saith and A n 27 is ma		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6801 Rapid Water Way #104 Glen Burnie, MD. 21060
Baltimore,	Peges 1. nent of He ant: if iten ury or oth		20a. Method of Disposition  1 \( \frac{1}{2}\) Burial 2 \( \subseteq \) Cremation 3 \( \subseteq \) Removal from State 4 \( \subseteq \) Donation 5 \( \subseteq \) Other (Specify) \( \subseteq \) Meadowridge Mem Park 2/14/2006 \( \subseteq \) Elkridge, Maryland
Balt	permit. Departimport eny inj		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225
	Physician		23a. Part. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  An UX C Encephal of parthy
	/Medical Examiner		Due to (or as a consequence of):  Sequentially list conditions,  b.
,	cate be executed oblysicien and the burial-transit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):
68760,	tificate be ig physicie as the bur	dical	d
Вох	ne death cer the attendir hed for use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1
rds, P.O.	w requires that the base of the control of the cont	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Onknown
Vital Record	The law requirele hes been page 2 should	Completed	24a. Was an autopsy findings available prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
Ĭ Ž	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:   Hospital:
Division of	ding h. After fune	ation: To	1 Yes 2 No Puspital: 1 Impatient 2 ER/Outpatient 3 DOA Virier: 4 Nursing Home 5 Residence 6 Other (Specify)  27. Many of Death 1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28b. Time of North N
Divis	To the Hospital or Attandi within 24 hours effer death. To the Funerei Director: A completely filled in by the fi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
,	To the Hospital or A within 24 hours effer To the Funerel Direct completely filled in by	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as elated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
)	withi To t	W	29b. Signature and title of certifier  Dence C. Will III M.D. 29c. License number  D41365  29c. License number  D41365  Ebruary 11, 2006  30. Name and address of person, who completed cause of death (Item 23a) (Type, Print)  Seorge E. Wilks III M.D. 301 Kospital Drive, Glan Burnie, Maryland 21061
		13	
	Sta Registr		31. Date filed (Month, Day, Year)  32. Registrar's Signature

 $\varphi$ 

Crouse, Olson

		1	For State Registrar	State	of Maryland		rtment of F tificate of	lealth and M Death			5 04	088
			Decedent's Name (First, Middle, Last)	)					2. Date of Dear Month		3. Tim	e of Death
	Physicia		Mar	garet	M. DiMis	sa Cori	rigan		Februa		006 2:10	AM M
	/Medic Examin		4a. Facility Name (If not institution, give	street and nu	ımber)		4b. City, Town, o	r Location of Death	TODICE	4c. County of		
	Examin	EI	5101 River	Poad .	#1617			Bethesda		M	ontgomer	v
	Funeral		5. Social Security Number 6. Se		7. Age (In yrs. I	ast birthday)	If Under 1 Year	if Under 24 Hrs.	8. Date of Birth (Month, Day	Year)	9. Birthplace (Sta Country)	ite or Foreign
	Director		060-24-0274	]M 2∭1F	75	Yrs.	Months Days	Hours Min.	May 9,	1930	New Y	
,			Usual Residence of Decedent								1011	02.11-2-
	ylan how		10a. State 10b. County		10c. City	, Town or Lo	cation					le City Limits Yes 27 No
:	a-f-	io	Maryland Montg	omery				Bethesda				183 ZA110
:	2 7 28 II	Director	10e. Street and Number				10f. Zip Code		1	l0g. Citizen of W	hat Country?	
İ	23a c		5101 Rive	r Road	#1617			20816			ted Stat	
	dee	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever in U. orces?	S. 13.	Was Decedent of It f Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		<ul> <li>American India:</li> <li>White, etc.</li> </ul>	٦,
۰	after or its		1 Never Married 21 Married		2 X No		1 ☐ Yes 2X No	Specify:		Specify:		
3	within 72 hours atter deeth with the Maryland ene. Then "natures", or iteme 23e or 28e-f ehow he Medical Examiner i ust be notified at	d by	3 Widowed 4 Divorced	Year or	Dates:						Whit	:e
215-0036	72 h natu	Completed	15. Decedent's Edi (Specify only highest grad		)	(Give	dent's Usual Occup kind of work done	during most of work	ring	16b. Kind of Bus	siness/Industry	
7	E . E	idu	Elementary/Secondary (0-12)		(1-4or 5+)		DO NOT use retire gistered	•		Medica	l Servic	
7	ygier ygier	S	(5 5 d 4 h) (5 - 4 h) diddle 1 and	5	+	ICE 8	STOCCICA	18. Mother's Nam	e /First Middle			
Maryland 2	be filed within 72 hours after deeth with the Marylan tal Hygiene.  do other then "natural; or iteme 23a or 28a-f ehow avent, the Medical Examinativations by notified at	Be	17. Father's Name (First, Middle, Last)					To. Would 3 run	•			
$\frac{8}{2}$	ould Men Marks Latic	မ		hn Jac	kson	405 14-115	- 6 ddaan (Chana	and Number or Rui		Heffern		
<u>a</u>	jes 1 and 2 should be filed w of Health and Mental Hygier If item 27 is marked other th or other traumatic event, the		19a. Informant's Name/Relationship (T				-					20016
<u>~</u>	and lealth m 27 her ti		John Patrick Corr	igan/	001 0		- 4: (4:	Road #16	Date		City or Town, Stat	
Ö	T te		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from	n State	ametery, crei	natory or other pla	Febru	ary 14.			
E	Pages ment of I ant: if its lury or o'		4 ☐ Donation 5 ☐ Other (Specify			of Hoo	tran Camai	tary 200	06	Silver S	ring, Ma	ryland
Baltimore,	permit. Pages Department of Important: If I' eny injury or o		21. Signature of Funeral Service Licen	\$80		Be	2. Name and Addr ethesda-C	ess of Facility Rob Chevy Chas Mary Land	ert A	7557 Wi	runera. .sconsin	Avenue
<u></u>	ă∆ E a a		May 11	1eg h	A M003	35 Be	ethesda,	Maryland	20814-3.	501		
			23a. Part1. Enter the disease, or composhock, or heart failure. List only	olications that one cause on	caused the deat each line.	h. Do not ent	er the mode of dy	ing, such as cardiac	or respiratory an	rest,		l Between and Death
	Physician		Immediate Cause (Final disease or condition	P	ulmonary	Fibro	sis					
/ ·	/Medical		resulting in death)	Due to	o (or as a conseq	uence of):						
	Examiner		Sequentially list conditions.	b								
	p ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to	o (or as a conseq	uence of):						
	nd nd trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c								
Ö,	e exe	ũ	resulting in death cast	Due to	o (or as a conseq	uence oi).						
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9	ing p	Mec	IF FEMALE:	00. 16						221.5-		
Вох	eath certific ettending p for use as	an/	23b. Was decedent pregnant in the past 12 months?	1 Live	outcome of pregna birth 2 Feta	ildeath 3[	Ectopic pregnanc	су		23d. Date Mor	e of delivery oth Day	Year
<u>.</u>	the e	Sici	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	4∐Pre 9□ Unk	gnant at time of d known	leath 5L	Other (specify)					
<u>о</u> .	thet the de ed by the detached	by Physician/Me	Part II. Other significant conditions of	ontributing to	death but not res	ulting in the s	inderlying cause g	iven in Part I	23e, Did to	obacco use contr	ibute to the cause	of death?
Ś	res the igned be de		Part II. Other significant conditions of	oninooning to	deall but not res	anang in tilo t	andonying oddoo g		1 🗆 Y	res 21X No	3 ☐ Probably	4 ∐Unknown
Vital Records,	w require been sig should b	Completed										
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	The ate h page	5							1 ☐ Yes		Yes 2 No	,
ita Ta	Physicien: The la this certificate hes ral director, page 2	Be (	25. Was case referred to medical examiner?				10	26. Place of Dea	th (Check only o	ne)		
o V	hysik his co Il dire	P	1 ☐ Yes 2 🔀 No			ER/Outpatie	nt 3 DUA		ome 5X Resid			
	ding Ph h. After th funeral	ä	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Dat (Mo	te of Injury onth, Day Year)	28b. Time o Injury	W		28d. Describe r	now injury occurr	90	
<u>.</u>	Attending r death. ector: After by the fune	cati	2 Accident investigation					]Yes 2 □No	005 1 1: //			Atombas
Division	for Attendated after death Director:	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	288. Fla	ce of Injury · At h Iding, etc. <i>(Speci</i>	iome, farm, st fy)	reet, factory, office	•	City or Tox	vn, State)	er or Rural Route	Number,
	spital or Attenions after deatlers after deatlers blrector:			11			CONTRACTOR					
	Fur 4 b	edicai	(Check only 2 Medical Exam	niner: On the	basis of examina	owledge, dea ation and/or ir	th occurred at the evestigation, in my	time, date and place opinion, death occu	rred at the time,	cause(s) and ma date and place, a	nner as stated. and due to the ca	use(s)
	To the Hos within 24 ho To the Fun completely	Med	one)	and m	anner stated.		29c Licer	nse number		29d. Date signer	1 (Month, Day, Ye	ar)
	10 10 00	-	29b. Signature and title of certifier	1	1/22	147		8676				
	7		1.005	WI	/_>	. M.		00/0		Februa	ary 10,	2006
	30 '			1/	use of death (Ite			Van-i	kan Ma	11 and 00	1805	
	_		Victor Steiger, M	. D. T(	1810 Cont . Registrar's Sign		ut Avenue	e Kensing	Lou, Mar	yrand 20	עקטו	
		ate rar	FEB 1 4 200	6	. Togistial 3 Gigit	And	de					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 10:20P M 6, February 2006 Bobby Wayne Carroll /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Co. Timonium Stella Maris Hospice Ctr. If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) April 7,1947 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** XXM 2□F Tennessee 58 Director 228-60-4827 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 28a-f ehow the Medical Exercities must be notified at 1 ☐ Yes 2 No Director Dundalk Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 21222 United States 8628 Sandy Plains Road or items 23a death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 X No Specify: Specify. White δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) other than Elementary/Secondary (0-12) Hygiene Steel Industry Steelworker 12 Years 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be t 2 should be fi h and Mental H marked Eva Harrison Kyle Carroll 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 s
Department of Health ar
important: if Item 27 le.
any injury or other trau 8628 Sandy Plains Road Dundalk, Maryland . 21222 (Wife) Brenda Carroll Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, MD Holly Hill Mem. Gdns. 2/8/2006 4 □Donation 5 ☑ Other (Specify) Entompment 21. Signatur of uneral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, shock, or heart ailure. Immediate Cause (Final **Physician** disease or condition resulting in death) KIDNEY CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the confine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 4 Pregnant at time of death 1 ☐ Yes 2 ☐ No page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed' 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ▼ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: al or Attending P after death. I Director: After After Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28t. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D43725 7/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. DR. TARIQ MAHMOOD 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 4 2006 Registrar

			For State Registrar	State of Maryland	-	irtment of H			_ Z U U b	04091
			Decedent's Name (First, Middle, Last)					2. Date of Death	. No.	3. Time of Death
	Physici		Edward A. Denhard	+				Month	Day Year	
	/Medio Examir		4a. Facility Name (If not institution, give si			4b. City, Town, or	r Location of Death		4c. County of Death	
	LAUIIII	٠.	Hospice of the Ch	esapeake		Linthi	cum		Anne Arun	le1
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	B. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign intry)
	Director		213-34-7982	M 2□F 67	Yrs.	Months Days	Hours Will.	Dec 17,	1938	MD
	pu 🛊		Usual Residence of Decedent  10a. State 10b. County	10c Cin	, Town or Loc	cation				10d. Inside City Limits
1	eho eho	'n								1 ☐ Yes 2☐ No
7	with the Marylen e or 28a-f ehow	ect	MD ANNE ARU	NDEL GLE	N BURN	I.E. 10f. Zip Code		100	. Citizen of What Cou	
enhard Format	alter deeth with the Marylend or fiteme 23e or 28a-f ehow	by Funeral Director	7221 JUDY RD.			21060	n	109	USA	nay:
9	after deeth w	era		2. Was Decedent Ever in U.	S. 13. V		lispanic Origin? (Spec an, Mexican, Puerto Ri	ifv Yes or No-	14. Race - Amer	can Indian,
5 %	after dee or iteme	Ē	1 ☐ Never Married 2XXMarried	Armed Forces? 1 KX es 2 □ No				ican, etc.)	Black, White	, etc.
> 8	hours a turel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1	I□Yes 2□No XX	Specify:		Specify: WH	LTE
Dev	n 72 hours "naturel", edical Exp	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup	ation during most of working	16	b. Kind of Business/l	ndustry
ي سرا	within 72 ene. then "nat	ηb	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	DO NOT use retired	1)			ri .
200	e filed within Hygiene.	ပ္ပ	12 17. Father's Name (First, Middle, Last)		POSTM	ASTER	10 Motherda Name (	(Cient Middle Ma	USP	5
- C	tall H	Be	AUGUST DENHARDT				18. Mother's Name (			
Q Z	2 should be in and Mental I	2	19a. Informant's Name/Relationship (Type	no Print)	10h Mailin	a Address (Street	and Number or Rural			a Codel
EDWARD A	s 1 and 2 should be filed within the Health and Mental Hygiene. Item 27 is marked other them other treumatic event, ILEM	i	MARY E. DENHARDT	e, rinij		-	GLEN BURN		•	p C009)
و ڪِ	permit. Pages 1 and 2 Depertment of Health i Important: If Item 27 I any injury or other tre once.		20a. Method of Disposition	20b. P	lace of Dispos	sition (Name of	Da		c. Location - City or 1	own, State
3 5	ages ant of t: If i		1 Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	·	natory or other plac	1			
A	ortar foliar		21. Signature of Funeral Service Lonse	• /) HO			ERY 120060 AL HOME, P		ALTIMORE,	MD
(1) a	permit. Depertrimports any injury.		KI GREGORY FINK	M0114			E, MD 2106			
			23a. Part . Enter the disease or complic shock or heart failure. List only on						t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		elio					Onset and Death 4 Month
	/Medical		resulting in death)	Due to (or as a consequ						1 Jordoctor
	Examiner		Sequentially list conditions, b.							
,	D =	iner	cause (Disease or injury	Directo (or as a consequ	aenca of):					
$\vee$	e be executed sician and burial-transit	Examiner	that initiated events c. resulting in death) Last	Due to for an a consequent						
9	cian cian burial	cal E		Due to (or as a consequ	ience oi):					
	cate phys		d							
Box 68	eath certificate attending phys	/We	IF FEMALE:	3c. If yes, outcome of pregna	ncv				23d. Date of deli	1001
ď	atten for u	clan	in the past 12 months?	1☐Live birth 2☐Fetal 4☐Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	1		Month	Day Year
٥	by the	Physician/Medi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐ Unknown		2 - 1 (-2-0-1.),				
۵	Attending Physician: The law requires that the death certificate redath.  actor: Atter this certificate has been signed by the attending phys the tuneral director, page 2 should be detached for use as the	by Pi	Part II. Other significant conditions con	tributing to death but not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
rde	quire n sig	d be						1 Yes	2 □ No 3 □ Pro	bably 4 Unknown
Ç	aw requir s been si s should I	ojet						24a. Was an	24b. Were au	opsy findings available ompletion of cause of
å	sician: The lav certificate has irector, page 2	Completed						autopsy performe	ed?   death?	ompletion of cause of 2 No
	lan: rtifice stor, p	Be C	25. Was case referred to medicat	-			26. Place of Death			
>	nysic onis ce	ToE	examiner? 1 ☐ Yes 2 XNo	ospital: 1   Inpatient 2	ER/Outpatien	it 3□ DOA Oth	ier: 4 Nursing Hom	e 5 Residen	ce 6 □Other (Spec	ify)
2	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor	y at 28	d. Describe how	injury occurred	
	death. ctor: A y the fu	catic	2 Accident investigation			M 1 🗆	Yes 2 □ No			
Division of Vital Becords	I or Attenation after deat Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Ptace of Injury - At he building, etc. (Specify	ome, farm, str /)	eet, factory, office	28	Bf. Location (Stre City or Town,	et and Number or Ru State)	al Route Number,
	urs al	ပိ								
	os or or or or or or or or or or or or or	CO	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my kno ler: On the basis of examina	wledge, death tion and/or inv	n occurred at the tir vestigation, in my o	me, date and place, ar opinion, death occurred	nd due to the cau d at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
	T 2 m 5	≚	unej	and manner stated.		29c. Licens	se number	290	d. Date signed (Month	Ogu Yoosi
	o the H ithin 24 o the F	Medical	29b. Signature and titte of certifier					1		, Day, rear)
	To the Hospital or Attendible of Attendible 24 hours after de To the Funeral Directe completely filled in by the Completely filled in by the Complete of the C	Medic	29b. Signature and title of certifier	can M.	·D	D.	39505		ebruar	4 13.2006
•		Medic	· mar	mpleted cause of death (Item	23a) (Type	Print) A	39505	. [4	ebruar	y 13,2006
•	To the H within 24 To the F complete	Medic	· mar	mpleted cause of death (Item	23a) (Type,	Print)  Spital	39505 Dive, G	len Bu	ebruar mie, r	y 13,2006 ND 21061
•	12	ate	· mar	32. Redistrar's Signa		D:  Spital	39505 Dive, G	len Bu	ibruar unie, A	y 13,2006

DHMH 17 Rev 1/2001

ORIGINAL

		1	For State Registrar	State of	Maryland /	Departme <i>Certific</i>				Reg. No. 0 0 8	04092
F			1. Decedent's Name (First, Middle, La	st)					2. Date of Dea		3. Time of Death
	Physicia /Medic	ai	Lorena Darder						Februar		
	Examin		4a. Facility Name (If not institution, giv					ocation of Death		4c. County of N/A	Death
		5 - 25	2336 West Lexi		reet 7. Age (In yrs. last b			If Under 24 Hrs.	8. Date of Birt	h 9	. Birthplace (State or Foreign
10	Funeral Director			□M 2\\ F		Yrs. Mont	ns Days	Hours Min.	Oct 7,	1930 No	Birthplace (State or Foreign Country) orth Carolina
	TO CONTRACT OF THE CONTRACT OF	- H	Usual Residence of Decedent		100 City To	wn or Location					10d. Inside City Limits
	show	.	Maryland N/A		Toc. City, To	Baltin	ore				1√2 Yes 2 □ No
	the M	Director	Maryland N/A  10e. Street and Number				Zip Code			10g. Citizen of Wha	at Country?
	with Me or 1		2336 West Lexingt	on Stre	et		2122	3		USA	A
	death me 23	Funeral	11. Marital Status		dent Ever in U.S.	13. Was De	ecedent of His	panic Origin? (Sp., Mexican, Puerto	ecify Yes or No	- 14. Race -	American Indian, White, etc.
9	or Its		1 Never Married 2 Married	1 Tes	2 No		s 2 No	Specify:	,		Black
21215-0036	hours after death with the Maryland tural', or Iteme 23e or 28e-f show at Exeminat must be rediffed at	d by	3 X Widowed 4 □ Divorced	Year or Da	ites:	a. Decedent's l	Isual Occupat	ion		16b. Kind of Busin	
5	22	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give kind of	work done du T use retired)	<i>iring</i> most of work	ring		,
212	with liene.	mo	Elementary/Secondary (0-12)	College (1	-40r 5+)	Nursir	g Assi	stant		Med	ical
b	2 should be filed within 72 hours after death with the Marylan n and Mental Hygiene. Its marked other than "netural", or Iteme 23e or 28a-f show reumetic event, the Mudical Exercities must be notified at	Bec	17. Father's Name (First, Middle, Last	)						, Maiden Sumame)	
ylaı	Menta	10	Staton Davis						a E. Sh		ata Zin Codo)
Maryland	2 sho		19a. Informant's Name/Relationship (Phyllis Darden -							er, City or Town, St . Marvlat	
	1 and Health em 27 ther t		20a. Method of Disposition	RidleyD	20b, Place	of Disposition	Name of		Date	20c. Location - Ci	
nor	ages nt of l t: If it		1 ☐ Burial 2 🂢 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State	ery, crematory Cremat			.0/06	Raltimore	e. Maryland
3altimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked eny injury or other treumetic ex once.	1	04 Simpature of Euporal Solving I		Metro						
ä	Departiment Department		Thomas Greer	region		299	Freder	ick Road	l Baltin	nore, Mary	viand 21228
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that co	ach line.				or respiratory a	rrest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	a. HEP	ATIC E	MEPI	InLofo	OTNY			6WEEKS
	/Medical Examiner		resulting in death)	Due to (	or as a consequenc	e of):					
œ		er	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consequenc	e of):					
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
oʻ	a exec an an irial-tr	Еха	resulting in death) Last	Due to (	or as a consequenc	e of):					
8760	requires that the death certificate be executed seen signed by the attending physician and hould be detached for use as the burial-transit	dicai	•	d							
9	ertific ding p	/Mec	IF FEMALE:	23c If yes out	come of pregnancy					23d. Date	of delivery
Вох	death certific attending p	cian	23b. Was decedent pregnant in the past 12 months?	1∏Live b	irth 2 Fetal dea		ic pregnancy r (specify)			Mont	
P.O.	the d	Physician/Me	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9□ Unkno	own						
	n requires that the death been signed by the atte should be detached for		Part II. Other significant conditions		eath but not resulting	g in the underly	ng cause give	n in Part I.			oute to the cause of death?
ğ	en sig	ted	DIABETES MEllIT	W					1	Yes 2 No 3	B ☐ Probably 4 ☐ Unknown
ecc	S E	Completed by	NYPERFERSION						24a. Wa auto	psv pr	ere autopsy findings available for to completion of cause of eath?
E B	Page 1	Co	DEPRESSION						1 ☐ Yes	2 No 11	Yes 2□No
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	(	Outration 20	Othe	26. Place of Dea		one) sidence 6 ⊡Other	(Specify)
to		To To	1 ☐ Yes 2€ No 27. Manner of Death	28a. Date		o. Time of	28c. Injury Work			how injury occurre	
on	Attending I r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending investigati		th, Day Year)	Injury M		Yes 2 □ No			
Division of Vital Records,	r Atte er deg recto by th	Certification:	3 Suicide 6 Could not determine	d 200. Place	of Injury - At home ing, etc. (Specify)	, farm, street, fa	actory, office		28f. Location City or To	(Street and Number own, State)	r or Rural Route Number,
Ö	itel or irs afte rel Dir lled in									(a) and man	nor as stated
	Hospitel	Medical	29a. Certifier 1 Certifying I (Check only one) 1 Medical Ex	aminer: On the b	e best of my knowled asis of examination oner stated.	and/or investig	ation, in my of	oinion, death occu	irred at the time	, date and place, ar	nd due to the cause(s)
	o the lathin 2 of the lathin 2 of the lathin 2 omplet	Med	29b. Signature and title of certifier	and man			29c. License	-		-	(Month, Day, Year)
D.	To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Med		tolero	MO		-	D 84		29d. Date signed	
	To the I	Med	29b. Signature and title of certifier	itolore	MA) se of death (Item 23	a) (Type, Print)	050	-		-	
4	To the I within 2. Within 2. I within 2. Complet complet	Med	29b. Signature and title of certifier	o completed cau	se of death (Item 23	ity Boı	056	p 86	ore, MD	2-9-	

UNK #06-01013 John W. Dickens Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item 28d per meo 8522 2-14-06 vt. State of Maryland / Department of Health and Mental Hygiene 06-01013 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 09 February 2006 JOHN W. DICKENS /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Interstate 95 Ramp to Interstate 195 Arbutus If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days 1□M 2□F OCT 14, 1944 VA Director 231.54.0371 Usuel Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Directo HILLSVILLE CARROLL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Iteme 23a 1777 FARMERS MARKET DR. 24343 Funerai death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No filed within 72 hours after 1 Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced WHITE Year or Dates: XX Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) other than GENERAL TRUCKING permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygies Important: If Item 27 is marked other tt any injury or other traumatic event, IIIs once. TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be ANNIE NEAL TICKLE DICKENS ALBERT ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1777 FARMERS MARKET DR. HILLSVILLE, VA 24343 TERESA LEWIS DICKENS 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation XX Removal from State - Ob FANCY GAP, VA 4 □ Donation 5 □ Other (Specify) DICKENS CEMETERY rve if Funeral Servic / Licensee 21. Signa FINK FUNERAL HOME, P.A. 426 CRAIN HWY SW GLEN BURNIE MD 21061 GREGORY FINK MO1148 of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Parl1. Enter the dieease shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** Multiple Imme Due to (or as a consequence of): resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) PO 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? N⊟Yes 2□ No 1⊠Yes 2□No or Attending Physician: 26. Place of Death [Check only one] 25. Was case referred to medical Be Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Scene 1⊠Yes 2 No Certification: To this After this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Tractor Trailer driver lost control

281. Location (Street and Number or Rural Route Number, City or Town, State) 1 Natural 5 Pending A M 9,2006 2 📝 No investigation 2:02 2 Accident feb 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Igs ramp of west 195, Arbuts, inserstate

Division within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifie

DHMH 17 Rev 1/2001

6/QenBers 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4

M.I

30. Name and address / person who comple ed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

27 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

OCME

29d. Date signed (Month, Day, Year)

February 9, 2006

111 Penn Street Baltimore, Maryland 21201

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 23a, b, c per doc 8852 2-14-06 vt
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No.... 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 6:01 P M February 6, 2006 Barbara Mary DiPaula /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Greater Baltimore Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. March Dy1, 1925 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 F **80** Scotland Director 078-18-4105 Usual Residence of Decedent 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or iteme 23s or 28e-f ehow the Medical Exactly or must be notified at 1 Yes 2XXNo Directo Baltimore Maryland Randallstown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3801 Schnaper Drive Apt. 305 United States of America 21133 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bleck, While, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: 1 Yes 2 No Specify: White þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Entreprenur Self Employed 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked John Joseph Breen ၉ Catherine McVey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Barbara Sealover (Daughter)

20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1 and 2 s Department of Health ar Important; if item 27 is any injury or other trau 3433 Liberty Garden Road, Baltimore, MD. 21244 Date 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 02/13/06 Owings Mills, MD. 21117 Garrison Forest Vet 21. Signature of Funeral Service 22. Name and Address of Facility Loring Byers Funeral Directors Olver MO0333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Pat 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Terminal Aspiration VOMITTALL **Physician** 30 MINUTES /Medical Due to (or as a consequence of): Severe Malnutrition Examiner 30 MINUTES ASPPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physicien and hed for use as the burial-transit 4 MONTHS Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🕱 No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown should l 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No 24a. Was an page 2 s autopsy performed 1 Yes 2 X No : After this certifice e funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 📉 No P 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours efter death To the Funerel Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

CHAN

FREO

with the Maryland

Maryland 21215-0036

Baltimore,

The law requires that the death certificate be executed

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

Si Paula,

Mental

31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

6701 NORTH

CHARLES

29c. License number

1) 5343 0

STREET

29d. Date signed (Month, Day, Year)

MARYLAND

7 2006

21204

FEBRUARY

BALTZMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month February R.SZAM **Physician** atricia ADavis 2006 13 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Baltimore Washington Medical Center Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F Yrs Maryland Director May 5, 1952 212-60-6158 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 le marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must in any once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Director Pasadena Maryland Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number **IISA** 21122 2961 Crystal Palace Lane Completed by Funeral 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗷 No white Specify: Specify: Baltimore, Maryland 21215-0036 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) BG&E Customer Representative 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lafferty Dolores M. Albert R. Mvers ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2961 Crystal Palace Lane, Pasadena, Maryland 21122 (Husband) Charles Davis 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ Removal from State Baltimore, Maryland 02/14/06 Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) McCully-Polyniak Funeral Home P.A. 3204 Mountain Koad, Pasadena, Maryland 21122 21. Signature of Fugeral Service License The Man1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ldan aspiration preumonia Physician /Medical week Examiner oncephalo pathu AIL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine heartic cirrhosis YUAKS burial-transit The law requires that the death certificate be executed Due to (or as a consequence of certificate has been signed by the attending physician irector, page 2 should be detached for use as the burial SALLA Division of Vital Records, P.O. Box 68760 alchoholum Physician/Medical IF FEMALE: 23d. Date of delivery 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 1☐Live birth 3 Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No mutabolic acidosis 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2.2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifications 25. Was case referred to medical examiner? o the Funeral Director: After this certific ampletely filled in by the funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Certification; To 1 🗌 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 27. Manner of Death 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

State Registrar

Nospital 31. Date filed (Month, Day, 2006

29b. Signature and little of certifier

30. Name and address of person v

npleted cause of death (Item 23a) (Type, Print)

Or. Glen Burny 32. Fegistrar's Signature

1)r.

2106 MD

29c. License number

1000 aa 443

29d. Date signed (Month, Day, Year)

				State of Marylar	nd / Depa	artme	nt of He	ealth and			000	01.0	06
			1 - State Registrar		Ce	rtifica	ite of D	Peath		Reg. No:	UUb	040	6
П	Physici	an.	Decedent's Name (First, Middle, Las						2. Date of Dea	Day		3. Time of	
	/Medic	al	Maria Luigia Di Lec 4a. Facility Name (If not institution, give			4h Cit	v Town or I	Location of Deat	February	9	2006 County of Death	4:25	РМ
	Examir	er	6716 Collinsdale Road	Street and rumbery			rkville		**		altimore		
	Funeral		Social Security Number 6. S		last birthday)	If Und	ler 1 Year s Days	If Under 24 Hrs Hours Min.	8. Date of Birt			place (State o	r Foreign
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	and and		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Lo	ocation						10d. Inside Ci	ty Limits
	Mary -feho	ţō	Maryland Baltimore	Pa	rkville							1 🗌 Yes	2 No
	h the	lrec	10e. Street and Number			10f. Z	Zip Code			10g. Citi	zen of What Cou	intry?	
	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or iteme 23a or 28a-f ehow ont, the Medical Examil ar must be notified at	Completed by Funeral Director	6716 Collinsdale Road				21234			Uni	ted States	S	
	er dea	nue	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	I.S. 13.	Was Dec If Yes, sp	edent of His becify Cuban	panic Origin? (S , Mexican, Puer	Specify Yes or No- to Rican, etc.)		<ol> <li>Race - Ameri Black, White</li> </ol>		
36	rs afte	by F	1 Never Married 2 Married 3 🛛 Widowed 4 □ Divorced	1 ∐ Yes 2 ∭ANo If Yes, Give Year or Dates:		1 🗆 Yes	2 🔀 No	Specify:			Specify: Whit	ta	
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and	i be fil ntai H ed ott	Be	17. Father's Name (First, Middle, Last) Pietro Carrardoro					Nunzia [	me (First, Middle, Nihawi	Maiden	Sumame)		
<u> </u>	should ad Me mark matic	၉	19a. Informant's Name/Relationship (7	vpe, Print)	19b. Maili	na Addre	ss (Street a		ural Route Numbe	r. City o	r Town, State, Zi	p Code)	
S	nd 2 salth ar 27 ie		Marianne Sowards - Dau				e Drive		Valley, PA				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show ery injury or other traumatic event, the Medical Examination and itled at QDGs.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □		Place of Dispo	sition (A	iame of r other place	)	Date	20c. Lo	cation - City or T	own, State	
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<u>.</u>	deat ed for	sicia	in the past 12 months? 1 ☐ Yes ②≅No	4☐Pregnant at time of €		Other (	pregnancy (specify)				Month	Day 1	rear .
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Division of Vital Records,	for A efter Direc	Certification:	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	fy)	reet, racti	огу, опісе		City or Tox		d Number or Rur )	ar Robie Num	Der,
_	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours eiter death.  To the Funerel Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the		29a. Certifier 12 Certifying Phy	ysician: To the best of my kno	owledge, deat	h occurre	ed at the time	e, date and place	e, and due to the	ause(s)	and manner as	stated.	
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exam	iner: On the basis of examina and manner stated.	ation and/or in	vestigation	on, in my opi	inion, death occ	urred at the time,	date and	place, and due t	to the cause(s	)
	To t	Σ	29b. Signature and title of certifier				9c. License				e signed (Month,		
				me MD			94	8400		2	-13-0	40	
-	5 7		30. Name and address of person who o		m 23a) (Type,	Print)	3.1.	N. Her	10 Tou	00.	Mn 1	13011	
	Sta	te	31. Date filed (Month, Day, Year)	32 Jegistrar's Sign	ature	<u> </u>	15/2	Unra	0 100	son	YMP 21	304	
	Registr		FEB 1 4 20	106	W A	- 40							

DHMH 17 Rev 1/2001

ORIGINAL

ŀ	1 - State Registrar	State of Marylar	nd / Department of H Certificate of I			ene	6 04097
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hysician /Medical	JANE ROMAINE ED	WARDS			Month 2	7 .	06 12:52 f
xaminer	4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or	r Location of Death		4c. County of	
	Franklinsqu	are HOSP	tal ROSE	dale		Balt	imore
neral	5. Social Security Number 6. Se	- ' '	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	. Birthplace (State or Foreig Country)
ctor	217-20-7000	□ M 2 □ <b>x</b> F 79	Yrs.		11/4/19	26 I	MARYLAND
4	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Location				10d. Inside City Limit
Be Completed by Funeral Director	MD BALTIMO		CARNEY				1 Tes 2 XN
by Funeral Director	10e. Street and Number	RE (	10f, Zip Code		10	g. Citizen of Wha	at Country?
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era	9002 NAYGALL ROA	12. Was Decedent Ever in U	.S. 13. Was Decedent of H			USA 14. Race -	American Indian,
Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give			Rican, etc.)		White, etc.
	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 🗖 No	Specify:		Specify:	WHITE
Completed	15. Decedent's Ed (Specify only highest grad	ucation	16a. Decedent's Usual Occup (Give kind of work done of	ation	1	6b. Kind of Busin	ness/Industry
d	Elementary/Secondary (0-12)	. College (1-4or 5+)	life. DO NOT use retired	doning most of working	,9		
် ပ		4 YEARS	HOMEMAKER			OWN HON	Æ.
Be	17. Father's Name (First, Middle, Last)		THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TWO IS NAMED IN COLUMN TW	18. Mother's Name	(First, Middle, M	aiden Sumame)	
2	FREDERICK A. HUE	BLER		MIRIAM	E. STRA	SINGER	
	19a. Informant's Name/Relationship (7		19b. Mailing Address (Street				ate, Zip Code)
	ANNE R. LAURIE/DA		9002 NAYGALL	-	WEY, MD	21234	
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐		Place of Disposition (Name of cemetery, crematory or other place	D:	ate 2	0c. Location - Cit	ty or Town, State
	4 □ Donation 5 □ Other (Specify		RDENS OF FAITH	CEM. 2/16	5/2006	PARKVILL	E, MD
	21. Signature of Funeral Service Licens	1.1	22. Name and Addres			N FUNERA	AL HOME, P.A.
	Teather P	Talfu	8521 LOCH			SON, MD	21286
	23a Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that carised the deat ne cause on each line.	<ul> <li>b. Do not enter the mode of dyin</li> </ul>	ig, such as cardiac oi	respiratory arres	st,	Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition	ACHF					Onset and Death
	resulting in death)	Due to (or as a conseq		, (			
	Sequentially list conditions,	· Kestirat	ory Distra	e 55			
Examiner	Sequentially list conditions, if city, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseq	uence ff):				
хап	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):				
calE							
		d					
/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna	ancy			23d. Date o	á dalisas.
Physician/Med	in the past 12 months?	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	I death 3 Ectopic pregnancy			Month	
ıysi	1 Ures 2 No 9 Unknown	9□ Unknown					
	Part II. Other significant conditions co	ntributing to death but not res	ulting in the underlying cause give	en in Part I.	23e. Did toba	acco use contribu	ite to the cause of death?
d by					1 ☐ Yes	2 No 3	☐ Probably 9 ☐ Unknown
lete					24a. Was an	24h Wei	re autoney findinge available
Completed					autopsy	ed? dea	
	25. Was case referred to medical				1□ Yes 2		Yes 2□ No
Be C	examiner?	Hospital:	EB/Outpotions 307 DOA Othe	26. Place of Death			
은	1 Yes 2 No 27. Manner of Death		Ervoutpatient 3 DOA	4   Nursing non	e 5 ☐ Resider 8d. Describe hov		(Specify)
후	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury Worl	k? Yes 2 □ No			
Certification:	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At he	ome, farm, street, factory, office	2	8f. Location (Stre	et and Number	or Rural Route Number.
erti	4 Homicide determined	building, etc. (Specif	y)		City or Town,		,
	29a. Certifier 1 Certifying Phy	rsician: To the best of my kno	wledge, death occurred at the time	ne, date and place, a	nd due to the cau	use(s) and manne	er as stated.
Medical	one)	and manner stated.	tion and/or investigation, in my of	pinion, death occurre	d at the time, dat	e and place, and	due to the cause(s)
Σ	29b. Signature and title of certifier	21-1	29c. License				Month, Day, Year)
	V Yolanda &	. Ajala My	KE:	5000	F	ebruary	12, 2006
1 1	30. Name and address of person who c	ompleted cause of death (Item	n 23a) (Type, Print)	0 '	•		
	0 A V						
	Pr. Yolanda Ajaja 31. Date filed (Month, Day, Year)	9000 Frank [1]	RES  n 23a) (Type, Print)  N Square Dril	re Bout	more	MJ 2	1237

To the Hospitel or Attending Physicien: The law requires that the death certilicate be executed within 24 hours after death.

To the Funerel Director: Atter this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

St Regist DHMH 17 Rev 1/2001

	Registrar  1. Decedent's Name (First, Middle, Lasi	7)	Cei	rtificate of E	veatn T	Reg. 1	fo.	3. Time of Death				
n	Sevasti Eliadi	•					), 2006	7:50 a <sup>M</sup>				
-	4a. Facility Name (If not institution, give			4b. City, Town, or			lc. County of Dea					
	Mariner Health	Glen Burn	ie	Glen	Burnie		Anne A	rundel				
	Social Security Number     6. Se	7. Age (In yrs.	last birthday)		46 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	8. Date of Birth (Month., Day, Yea	9. Bir	thplace (State or Foreign				
	001-22-8347	☐M 2戶F	85 Yrs.	monard Sayo	110013	11/11/	19 G	réece				
-	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ecation				10d. Inside City Limits				
0	Md Baltin	nore	Di	ındalk				1 ☐ Yes 2 🗖 No				
Director	10e. Street and Number			10f. Zip Code		10g. (	Citizen of What Co	ountry?				
	7908 Wise Ave.			2122	22		USA					
Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cuban	panic Origin? (Spe	cify Yes or No-	14. Rece - Ame					
	1 Never Married 2 Married	1 ☐ Yes 2 KI No If Yes, Give		1 ☐ Yes 2 🖾 No	Specify:	iloan, etc.)	Black, Whit	e, etc.				
d by	3 XWidowed 4 ☐ Divorced	Year or Dates:						White				
lete	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupat kind of work done di DO NOT use retired)	ırina most of workir	ng 16b.	Kind of Business	Industry				
Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	Seamstre			Tailor					
	17. Father's Name (First, Middle, Last)	0				(First, Middle, Maid						
o Be	Nicholas Kala	ftas			Maria	Alexia	des					
	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street a	nd Number or Rura	Route Number, City	or Town, State,	Zip Code)				
П	Mr. John Eliad	is / Son		Wise Av								
	20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of matory or other place	D		Location - City or					
	1  Burial 2  Cremation 3  □ 1  Other (Specify)	Hemovai from State		rthodox	2/14	/06 W	oodlawn	. Md.				
	21. Signature of Funeral Service Licensee											
	23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Lists by one cause on each line.  Approximate interval Between											
cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Jacobs Chipa) that initiated events resulting in death) Last	b. Due to (or as a consequence to consequence)  Due to (or as a consequence to consequence)  Due to (or as a consequence to co	uence of):									
hysician/Medi	IE EEMALE:	d	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year				
leted by P	Part II. Other significant conditions co	ntributing to death but not res	ulting in the u	nderlying cause give	n in Part I.	23e. Did tobacc		the cause of death? obably 4 Unknow				
Complet						24a. Was an autopsy performed?	prior to death?	utopsy findings availab completion of cause of				
Be	25. Was case referred to medical examiner?	14			26. Place of Death	(Check only one)						
္	1 ☐ Yes 2 ☐ Alo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3□ DOA Other	4 4 Nursing Hom	ne 5 Residence	6 ☐ Other (Spe	cify)				
ation:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work'		8d. Describe how in	jury occurred					
ertificati	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	8f. Location (Street City or Town, Sta		ural Route Number,								
ledical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medicel Exem	rsicien: To the best of my kno iner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the time vestigation, in my opi	e, date and place, a nion, death occurre	nd due to the cause d at the time, date a	(s) and manner as nd place, and due	s stated. to the cause(s)				
Me	29b. Signature and title of certifier	1 , ,	1	29c. License	number	29d. [	Date signed (Mont	h, Day, Year)				
	> hunta	Sha r	10	D51	104	Fo	bruary	13, 2006				
		ompleted cause of death (Item	00-) (**			1.6	bruary	13, 2000				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 23a per doc 2854, 4-13-06 vt.
State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 8 **Physician** 2015 2006 Vesbitt 7+ch /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, **Examiner** Baltimore Baltimore Special University If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Unce 11, 9. Birthplace (State or Foreign Country) New York Age (In y 5. Social Security Number s. last hirthday) **Funeral** Months 1 XM 2 F 1927 112-16-9077 78 June Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location 10b. Count permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 X No Director Crownsville Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21032 **USA** 1075 St. Stephens Church Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

182 Yes 2 No 1945
If Yes, Give Year or Dates: 1947 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: White 3

Widowed 4 □ Divorced þ Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education itch, Nesbit (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Executive Chef Restaurant 8 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be UNK UNK 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1001 Chesterfield Road Annapolis, Maryland 21401 <u>Larry Sager, Friend</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2X Cremation 3 Removal from State
4 Donation 5 Other (Specify) 02/13/06 Baltimore, Maryland Metro Crematory Inc. 22. Name and Address of Facility
Cremation Society Of Maryland Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Consee Thomas Gregor 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Pullmonary Tuborculogic Approximate vai Retweer Pulmonary Tuberculosis Onset and Death Immediate Cause (Final Physician Costerv disease or condition resulting in death) /Medical Due to (or as a conseq ance of Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examine the attending physician and hed for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 1 signed by th 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate has page 2 1 Yes 2 No 1 Yes 2 7 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA this 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: After 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 south charles street 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HIRBARUA MS 601 ZAYMVT 32. Registrar's Signature 31. Date filed (Month, Day, Year) State miles

Registrar

В 14 2006

			1 - For State Registrar	State of Maryla		artment of H rtificate of L		Re	g. No. UUD	04100
	Physici	an	Decedent's Name (First, Middle, La			~		Date of Death     Month	Day Year	3. Time of Death
	/Media	al	ANTHON'		/	-12/AGO		FERRUAL		
<i>*</i>	Examir Funeral Director	ier	4a. Facility Name (If not institution, giv 5. Social Security Number 6. S 171-10-2633	IEW MEDICAL	rs. last birthday)		Hours Min.	8. Date of Birth (Month, Day, Jan. 17,19		
	pu s		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	neation				10d. Inside City Limits
	Aaryla sho	ច	MD N/A	100.	Baltim					1 Y Yes 2 □ No
	28a-	rect	10e. Street and Number		54101111	10f. Zip Code		10	g. Citizen of What Co	
	3a or	O O	3029 E. Northern Par	<i>cway</i>			21214		U.S.A.	,
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Iteme 23a or 28a-f show says injury or other treumatic event, Ita Medical Exaction man be notified at ance.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Spin, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	te, etc.
5	72 h 'natu	etec	15. Decedent's E (Specify only highest gra	ducation ide completed)	(Give	dent's Usual Occupa	furing most of work	ina	6b. Kind of Business	/Industry
121	Mithin ine. ihen	mpi	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retired	)			
р Б	filed v Hygie Ither t	CO	12 17. Father's Name (First, Middle, Last			Factory W	OPKEP 18. Mother's Name	e (First Middle M	Factor	<u>'</u> Y
ano	d be ental	To Be	Angelo Filiaggi				Lydia J		alderi Garriame)	
ary	shoul nd M	ř	19a. Informant's Name/Relationship (	Type, Print)	19b. Maili	ng Address (Street a			City or Town, State,	Zip Code)
ž	elth a		Mrs. Rita M. Filiagg	i/ Wife	3029	E. Northern	Parkway B	altimore,	Maryland 212	214
J.	of He		20a. Method of Disposition		Place of Dispo	osition (Name of matory or other place			20c. Location - City or	
<u>Ĕ</u>	Page nent ent: M		1 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the contro		Parkwood		2/13	/06 B	altimore Mar	vland
Baltimore,	permit. Depertium on the control of		21. Signature of Funeral Service Lice	Heather Ca	in 📗	2. Name and Address 305 Harford		Leonar	d J. Ruck, I	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the done cause on each line.						Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	a ASO	CVD					Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):					
	ZAGIIIII	-	Sequentially list conditions.	b. PNEUY	MONIA					
Т	ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	211		0			11	
	execu and al-tra	xar	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):	T				
38760,	cate be executed physician and the burial-transit	dicai		d						
_		0 0								
P.O. Box	that the death certificated by the attending point of the detached for use as	Physiclan/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time of 9 ☐ Unknown	etal death 3[	Ectopic pregnancy Other (specify)			23d. Date of de Month	livery Day Year
	res that igned by be deta	by Ph	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
rds	quires n sign							1 ☐ Ye	s 2□No 3□P	robably 4 Unknown
l Records,	The law requires that the sete has been signed by the pege 2 should be detache	Completed						24a. Was ar autopsy perform 1 Yes 2	prior to death?	utopsy findings available completion of cause of
/ita	ysician: Th is certificete director, peg	Be	25. Was case referred to medical examiner?	11		- V.	26. Place of Deat	h Check only one	9)	
Division of Vital	w :=	၉	1 ☐ Yes 2 🛣 No		ER/Outpatie		#   Nuising no		nce 6 Other (Spe	ecify)
n C	ing After une	Ö	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	Worl	rat ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred	
isi	if or Attending after death. Director: After In by the fune	ficat	2 Accident investigatio 3 Suicide 6 Could not b	000 Dines of lainer 4	t home farm st			28f Location (Str	reet and Number or R	ural Poute Number
Θį	2 2 2 2	Certification:	4 ☐ Homicide determined	building, etc. (Spe	ecify)	out, ractory, office		City or Town	, State)	orar ricote rightser,
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	dical	29a Cartilier 1 A Certi in Pi (Check only 2 Medical Example)	nysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, dust ination and/or in	h occurred at the time vestigation, in my of	le, date and place pinion, death occurr	and due to the ear	ues(t) and manner a ite and place, and du	s stated. e to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	O 2111 M 61-	CLOW	29c. License		29	d. Date signed (Mon	th, Day, Year)
)	. 1		> Weller	WILLIAM CA	FCKLF	TMD RE	5 -000		2/10/	06
	3ta		30. Name and address of person who	completed cause of death (	Item 23a) (Type,	Print)				
	- 1		Q. William Checkley	4940 BASTE	W AVE	NUE BAL	TIMORE	mD.	21224	
	Sta Regist		31. Date filed (Month, Day, Year) 7 FEB 1 4	32. Régistrar's Si	gnature	parte	•			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 0845 2004 February 11 Donald M. Grim Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Cheaspeake Hospital Bel Air Harford 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 □ M 2 □ F Months 68 212-36-0103 June6,1937 Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County if in marked other than "natural," or items 23a or 28a-f show treumatic systit, it is Moulcal Exactions make reliifed at 1 ☐Yes 2 X No Director Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3635 Woodsdale Road 21009 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 25 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian. Black, White, etc. 1 Never Married 2 Marned 1 Yes 2 No Specify: Specify: White Completed by 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Reliance Fire Elementary/Secondary (0-12) College (1-4or 5+) Pipe Fabricator Protection 12th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be fill ment of Health and Mental Health and Instruct If Item 27 is marked off Charles E. Grim Elsie Brenneman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Pietrogiacomo/daughter 4206 Baylis Court Belcamp MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: if it any injury or o 1 □ Burial 2 □ Cremation 3 □ Removal from State SacredHeartofJesus 2/15/06 Baltimore MD. 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses ConnellyFuneralHomeofEssex 300 MAce Ave. Baltimore MD 21221 Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Infarction Myocardial 3 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner inding physicien and use as the burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month 4☐Pregnant at time of death signed by the at 1 be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Prostate Adenocarcinoma 1 Yes 2 No 3 Probably 4 Stonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2☐ No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Depatient 2 ER/Outpatient 3 DOA 2 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 5 Pending death. M 1 TYes 2 □No investigation 2 Accident Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospitel or within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier D35012 2 North Ave BelAir, Md. 21014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LYNCH M.D. Levin 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

	1	For State Registrar	State of M		Depa		lealth and	Mental Hy		9006	04102
Physician /Medical Examiner Funeral Director	4	214-82-5584	street and number,	ge (In yrs. last bi	rthday) Yrs.	4b. City, Town, or April 1 Vice 1 Year Months Days	Location of Dea	S. 8. Date of Bir	Da 40 th ay, Year,	County of Deal	3. Time of Death  A M  th  th  th  Control  Maryland
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ath with the 123a or 20 usl be no		10e. Street and Number 2725 West Walbrook A			-,	10f. Zip Code	21216			tizen of What Co	.A.
urs after al', or ite xamine	2	1. Marital Status  1. Never Married 2. Married  3. Widowed 4. Oivorced	12. Was Decedent Armed Forces' 1 Tes 2 In If Yes, Give Year or Dates:	?	If	/as Decedent of H Yes, specify Cuba □ Yes 2 1 No	ispanic Origin? ( in, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)	)-	14. Race - Ame Black, Whit Specify:	
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ges 1 and 2 should be it of Health and Mental if I Item 27 is marked or or other traumatic ev	_	19a. Informant's Name/Relationship ( Bertha Godwin	Гурө, Print)		27	25 West Wa		Rural Route Numb	e, Mai	ryland 2121	6
permit. Pages 1 ar Department of Hea Important: If Item any injury or othe once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Specifications)  21. Signataration	1)	romete	_Mt.	ition (Name of atory or other place Zion Cemete Name and Addre	ery	02/10/06		cation - City or	
Medical Examiner  be executed by the principle of the pri		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (of as	s a consequence	of):	vuit on him him	, a				Onset and Death
irres that the death certificate be executed signed by the attending physician and de detached for use as the burial-transit the by Physician/Medical Examir		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2 ☐ Fetal death at time of death		Ectopic pregnancy Other <i>(specify)</i>				23d. Date of de Month	livery Day Year
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The law ate has b page 2 st	and -							24a. Was auto perfo 1  Yes		prior to death?	utopsy findings available completion of cause of
hysiclan this certifical director		25. Was case referred to medical examiner? 1 □ Yes 2 No 27. Manner of Death 1 Natural 5 □ Pending	Hospital: 1 (Minpati 28a. Date of Inj (Month, Da	ury 28b.	utpatient Time of Injury	3 □ DOA Oth	er: 4 □ Nursing y at k?	eath (Check only of Home 5 Resi 28d. Describe	dence		cify)
tal or Attanding P s after death. al Director: After ed in by the funeractors.		Accident investigation    Accident investigation	9 28e. Place of In	njury - At home, f tc. (Specify)	arm, stre		Yes 2 □ No	28f. Location ( City or To			ural Route Number,
in 24 hours in 24 hours he Funer pletely fill	200	(Check only 2 Medical Exar	ysician: To the best niner: On the basis of and manner s	of examination as	e, death nd/or inv	estigation, in my o	pinion, death occ	ce, and due to the curred at the time,	date an	d place, and due	e to the cause(s)
To t To t com		29b. Signature and title of certifier  11. 13. Name and address of person who	completed cause of	death (Item 22-)	(Tuno 5	29c. Licens				ate signed (Mont	
State	. II	31. Date filed (Month, Day, Year)	Li 34 A	death (item 23a)	Туре, Р	larp Ad	124	udglist	Jeyr	pron	igland

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death <sup>Day</sup> 2006 **Physician** February 9, Dorothy 7:02PM Ellen Geigen /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Franklin Square Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | August 10,1923 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 □ VF Maryland 212-22-6583 82 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23s or 28e-f ehow the Medical Examiner must be rivillied at 1 ☐ Yes 2 No Director Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 2146 Vailthorn Road 21220 U.S.A. Funeral filed within 72 hours after deeth Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 🕅 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. 2 3 Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Hame other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ent of Health and Mental in it it item 27 is marked of yor other transmission. .. Pages 1 end 2 should be then to Health and Mental John Keller Minnie Machin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth E. Cobb - Daughter 34 Stemmers Run Road Baltimore, Maryland 21221 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department Important: If any Injury o 2/13/06 Parkwood Cemetery Baltimore, Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licensee Heather Cain Lease 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhanic /Medical Due to (or as a consequence of) Examiner erebral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physicien: The law requires that the death certificate be executed heime end attending physicien e for use as the burial-Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 2 Fetal death 3 Ectopic pregnancy Day Month 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 2 No 1 ☐ Yes 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Peath

1 Natural

Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours efter death.

To the Funeral Director: A completely filled in by the ft 1 Yes 2 No death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 02/10/2006 and address of person who completed cause of death (Item 23a) (Type, Print) MD 37/to, Eastern Ave, 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar 4 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 20a b.c per fh 856 6-7-06 yt.

State of Maryland / Department of Health and Mental Hygiene Reg. Na. UUS Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year 53PM HARRIS Physician EONARDO 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MEDICAL CENTER JOHNS HOPKIND BAYVIEU BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JUNE 3, 14958 Birthplace (State or Foreign Country)
 MT 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** MD 47 216-72-5865 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County il Hygiene. other than "natural", or Itama 23a or 28e-1 ahow vent, the Medical Examiner must be nutified at 1 XYes 2 No TURNER STATION BALTIMORE by Funeral Director MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21222 530 NEW PITTSBURG AVENUE Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Anned Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1976 14 Bace - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1X Never Married 2 Married BLACK 1 ☐ Yes 2√2 No Specify 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) BAKERY BAKER Ith and Mental Hygid 27 Is marked other r traumatic avent, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be DOLETHIA PHILLIPS ဥ JOSEPH S. HARRIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 518 N. HIGHLAND AVENUE, BALTIMORE, MD 21205 f Health it MARVIN WILLIAMS/NEPHEW 20h Place of Disposition (Name of Metres of Tampeton Ace)
GARRISON FOREST V.A. Pate 20c. LaBrach Time Fem. State 20a Method of Disposition permit. Pages 1
Department of H
Important: If its
any injury or ott TEXPurial 2 Cremation 3 Removal from State 02/<del>17</del>/06 OWINGS MILLS, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., 21. Signature of Funeral Service Licenses 1701 LAURENS ST., BALTIMORE, MD 21217 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death HYPOXIA Immediate Cause (Final MINUTES **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): EARS Examiner CARDIOMYOPATHY CHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine anding physicien end use as the burial-transit or Attanding Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 DUnknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2 No 1 Yes this certificate After this certifica funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 1 ☐ Yes 2 DNo 1 / Inpatient 28d. Describe how injury occurred 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 1 Natural 5 Pending To the non-position death.

Within 24 hours efter death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide o the Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier REJ-000 2006

State Registrar

121

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

JOHNS HOPKINS BAYVIEW MEDICAL CENTER

4940

EXITERA AVENUE

BALTIMORE, MD 21224

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

.1. M

32. Registrar's Signature

Matthins HOLDHOFF

1 4 2006

31. Date filed (Month, Day, Year)

FEB

NLM 06-01006 Warren Hu

ren Hur	st	Amend Unpend	item#1,23a,27, pe State of Marylan	n <b>ME 2853.</b> id / Depart	3/13/06 Ti	ealth and N	Mental Hv	aiene	g.2.o.	
		1 - For State Registrar	,, <b>,</b>		ficate of i			Reg. Ne.	06	04105
Physic	cian	Decedent's Name (First, Middle, Las	warren coornage	Hurst, J	6		2. Date of De Month	ath Day	Year	3. Time of Death
/Med	ical	Warren C.					Februa		2006	5:29 P
Exam	iner	4a. Facility Name (If not institution, give Saint Agnes Hos		4		Location of Death		4c. County of Death N/A		
Funera		5. Social Security Number 6. Se	7. Age (In yrs.		f Under 1 Year	Itimore If Under 24 Hrs.	8. Date of Bir	th		place (State or Forei
Director		Usual Residence of Decedent		65 Yrs.	fonths Days	Hours Min.	8. Date of Bir (Month, Da April	12,194		yland
e Marylar 8e-f ehow	ctor	Maryland Baltin		y, Town or Locat						1 ☐ Yes 2 🛣 N
with th	Dire	10e. Street and Number			10f. Zip Code			10g. Citizen		ntry?
eath v	erai	43 North Prospect	12 Was Decedent Ever in II	S 12 Wo	2122		acifu Voc or No		USA Race - Ameri	nan Indian
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event, the Medical Examinar must be notified as any once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☼Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:		es, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto Specify:	Rican, etc.)		city: White	etc.
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t be find H and ot	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam			iame)	
thould Me mark	10	Warren C. Hurst  19a Informant's Name/Relationship (7)	voe Printl	19b Mailing A	Address (Street	ROSAL and Number or Rui	yn Mill		vn State Zi	Code)
nd 2 solith an alth ar 27 is		Charles J. Hurst,				Court Pas				
S 1 a of Heem of Heem		20a. Method of Disposition	20b. P	Place of Disposition	on (Name of		Date	20c. Location		
permit. Pages 1 a Department of Hee mportant: If Item any Injury or othe once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify,	Hemoval from State	-		02/1	4/06	Baltime	ore, M	laryland
permit. Departr Imports any Inje		21. Signature of Funeral Service Literary Thomas Gregor	500	Mac Mac	ame and Addres	s of Facility	me P.A.			and 21228
sath certificate be executed  Wedical  Talending physicien and for use as the burial-transit		Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Hypertensive At  Due to (or as a consequence)  Due to (or as a consequence)  Due to (or as a consequence)	uence of): uence of):	otic Card	iovascular	Disease			Onset and Death
ficate p phys			d							
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clan: ertific ector,	Be	25. Was case referred to medical examiner?				26. Place of Deat	n (Check only c	ne)	/	
Physician: rthis certifica ral director, i	2	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☑ 28a. Date of Injury	ER/Outpatient		4   Nulsing ric	ome 5 Resid			<b>'</b> ሃ)
ending sath. or: After	ation	1 Natural 5 ☐ Pending investigation	(Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1 🗆 `	rat k? res 2 □ No	28d. Describe l	now injury occ	curred	
To the Hospital or Attending Physician: within 24 hours aftar death. To the Funerel Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	ome, farm, street, y)	factory, office		28f. Location ( City or Tox		m <i>ber</i> or Rur.	al Route Number,
Ne Hospl	Medical	29a. Certifier 1 ☐ Certifying Phy (Check only one)	sician: To the best of my knowiner: On the basis of examination and manner stated.	wledge, death oc tion and/or invest	curred at the timi igation, in my or	e, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and plac	manner as s e, and due t	tated. the cause(s)
To the within To the comp	ž	29b. Signature and title of certifier			29c. License	number		29d. Date sig	ned (Month,	Day, Year)
		30. Name and address of person who co	ompleted/dause of death (Item	23a) /Tune Prin	OCI	Œ		Febru	ary 9	,2006
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State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	Otate of Marylan		rtificate of			Reg. No.	16	04106
	Physici	an	1. Decedent's Name (First, Middle, La	·	<u>-</u>			2. Date of De		Year	3. Time of Death
	/Media		Anthone L.	Hood				Februa	ry 08,2		22:05 P M
7	Examir	ier	4a. Facility Name (If not institution, giver Prince George's I		_	Chever 1	or Location of Death		4c. County		orge's
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birthr	place (State or Foreign
	Director		373 30 0030	1 □XM 2□ F 42	Yrs.	Months Days	Hours Min.	(Month, Da 10/22		Wash	Ington, DC
	and *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation				1	0d. Inside City Limits
	Maryli f eho	tor	MD Prince G		tsvill						XXYes 2 □ No
	r 28a	rec	10e. Street and Number	66186 5 -7.00		10f. Zip Code			10g. Citizen of	What Cour	ntry?
	th with	aiD	5208 Spring Lan	е		20	781		United	1 Sta	tes
	tems	ne	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	.S. 13.	Was Decedent of I	Hispanic Origin? (Sp pan, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. Rad Bla	ce - Americ	an Indian, etc.
36	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Items 23a or 28a-f ehow int, the Madical Examinat must be notified at	by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed ※☐ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give A Year or Dates:		1 ☐ Yes 2√☐ No	Specify:		Specif	v: B1	ack
Maryland 21215-0036	2 hou	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation		16b. Kind of B	usiness/In	dustry
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anc	d be findal F.	To Be	17. Father's Name (First, Middle, Last,  Leroy S. Hood	)			18. Mother's Name			ne)	
Z	2 should be fi and Mental H ie marked of raumatic ever	ĭ	19a. Informant's Name/Relationship (	Type, Print)	19b. Mailir	ng Address (Street	t and Number or Run	al Route Numbe	er. City or Town.	State. Zip	Code)
	1 end 2 Health a lem 27 le		Shauna D. Hood (	Daughter)	689 M	t Lubent	iand Number or Rur ia Court I	West U	ppér Mai	rlbor	o, MD 20774
ore	of He of He fiterr		20a. Method of Disposition  M☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	lace of Dispo	osition (Name of matory or other pla	109)	Date	20c. Location -		wn, State
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 ie marked other then "natural", or items 23e or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at onc.		21. Signatur of Fregal Service Live	nsun Jan			ensburg R				
			23a. Part 1. Enter the disease, or com shock, or heart failure, List only	plications that caused the death one cause on each line.	n. Do not ent	er the mode of dy	ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition resulting in death)	a. Head and N	wk &	inunta					Onset and Death
	/Medical Examiner		resulting in dealin)	Due to (or as a consequent	uence of):						
	*	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or as a sonsequ	uerice of):						
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s, P	res that the de signed by the e i be detached i	by P	Part II. Other significant conditions of	contributing to death but not resu	ulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use cont	ribute to th	ne cause of death?
ord	w require been si should t							101	/es 2□No	3 🗌 Prob	ably 4 Unknown
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	ding Phy h. After this funeral c	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of		' <sup>191</sup> . 4 □ Nursing Ho ry at		now injury occur	-	met dire of
Division	Attending r death. •ctor: After by the fune	Certification:	1 □Natural 5 □ Pending 2 □Accident investigation	Fam 2/8/06	Found 201	2000	Yes 2 No	while	- while		dot
ΪŞ	or Attendations after deati	Ħ	3 Suicide 6 Could not b		ome, farm, str	eet, factory, office	N. A. C.	28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	
	pitel ours a perai D		202 Codifice 1 Cartifying Bh	No.		4		hours	food a	Level	May and
	To the Hospital or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	edical	29a. Certifier  (Check only one)  1 Certifying Ph	nysicien: To the best of my kno- niner: On the basis of examinal and manner stated.	tion and/or in	vestigation, in my	me, date and place, opinion, death occurr	and due to the e	cause(s) and ma date and place,	anner as st and due to	ated. the cause(s)
	within To the	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Date signe	d (Month,	Dey, Year)
	as I		1 history	U Vine		0.C.1	M.E.	I	February	09,	2006
11	) [		30. Name and address of person who	completed cause of death (Item							
1			THE DONE M. Kn 31. Date filed (Month, Day, Year)		tura	4	et, Baltim	nore, Ma	ryland	21201	
	Sta Registr		FEB 1 4	32. Registrar's Signa	A A	porte					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Feb 3, 2006 Year Physician 10:30 a **David Harmon** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore 2028 Druid Hill Avenue - 2nd Floor If Under 1 Year | If Under 24 Hrs. 8 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 10M 20F Days So. Carolina 250-46-6832 75 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 ahow the Medical Examiner must be notified at Baltimore 1 Yes 2 No N/A Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2028 Druid Hill Avenue 21217 U.S.A death o filed within 72 hours after deal Il Hygiene. Other then "natural", or Itema 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 200 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done di life. DO NOT use retired) during most of working Johns Hopkins Hospital College (1-4or 5+) Elementary/Secondary (0-12) Housekeeping Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked oth any liqury or other traumatic event ang. ilqury 17. Father's Name (First, Middle, Last) Rosa Bell Harmon Tom Harmon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5814 Ethel Berth Avenue Baltimore, Maryland 21215 Gussie McFadden Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 02/09/06 Catonsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death D6 Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner heoscleos is Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner attending physicien and for use as the burial-transit be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No certificate has 1 ☐ Yes 2 ☐ MG funeral director, 25. Was case referred to medical Be 26. Place of Death | Check only one examiner Other: 4 Nursing Home 5 Desidence 6 Other (Specify) 1 Yes 2 → 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manney Death 28b. Time of 28d. Describe how injury occurred After 1 atural 5 Pending death. 1 Tyes 2 No 2 Accident investigation the after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 0 within 24 hours a To the Funeral I Hospital 29a. Certifier 1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) the certifier 29d. Date signer (Month, Day, Year) 29b. Signature and title 2606 completed cau 1356 \$200 Baston Are pullo MD 21224 ms 32. Registrar's Signature 31. Date filed (Month, Dav. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. WILLIAM E. HAILEY State of Maryland / Department of Health and Mental Hygiene For State Registrer Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Edward Hailey 8 2006 FEB. 0656 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 911 DORKING ROAD GLEN BURNIE ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar. 22, 1 Birthplace (State or Foreign Country) **Funeral** Months 1 X M 2 □ F 219 96 2629 24 Director 1981 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State Item 27 is marked other than "natural", or items 23s or 28s-1 show other traumatic event, the Modical Examinar must be nutified at 1 ☐ Yes 2 No Directo Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S. 21061 911 Dorking Road Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Pueno Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, While, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Driver Tow Truck 10th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Betty Joan Keyser and Menta William Albert Hailey, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 Is eny Injury or other tra Glen Burnie, Maryland 21061 911 Dorking Road Laurie Hailey / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Deurial 2 Cremation 3 Removal from State Glen Haven Mem. Park 2/14/2006 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. Baltimore, Maryland 21225 come 4001 Ritchie Highway monucionoli 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ina disease or condition resulting in death) /Medical Due to (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The faw requires that the death certificate be executed ettending physicien and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. certificate hes been signed by the trector, page 2 should be deteched in 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 🛛 No 3 Probably 4 □Unknown 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ™Yes 2 □ No 1⊠ Yes 2□ No After this certifical funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) AT SCENE 1 TYes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury Coun 28b. Time of Council (Month, Day Year) Injury Certification; 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending hanged selt -8-06 1 Tyes 06:53 investigation 2 Accident the Director: 6 Could not be determined 3 Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Locatton (Street and Number of Rural or Rural Route Number, filled in by backyers within 24 hours e To the Funerel D Hospitel 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) ë. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E FEB. 8, 2006 eni of death (Item 23a) (Type, Print) Name and address of person who completed eaus

Registrar DHMH 17 Rev 1/2001

State

ORIGINAL

32. Registrar's Signature

111 PENN STREET, BALTIMORE, MARYLAND 21201

State of Maryland / Department of Health and Mental Hygien® For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** February 8, 2006 7:45 P Barbara Davis Hobbs /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 9707 Old Georgetown Road #1414 <u>Bethesda</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 13, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 5. Social Security Number **Funeral** 1 □ M 2 🖾 F Days Hours Min. 1912 Washington, Director 577-03-2400 93 Usual Residence of Decedent deeth with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Heelth and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-1 ehov other traumatic event, the Madical Examinar must be notified at 28a-f ehow 1 ☐ Yes 2X No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20814 United States Funerai 9707 Old Georgetown Road #1414 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural; or item eny injury or other traumatic event, the Madical Examina 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Secondary (0-12) College (1-4or 5+) Public Schools Secretary 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fred Phillip Davis ٩ Anna Marion Dow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael E. Hobbs/Son 419 Cameron Street, Alexandria, Virginia 22314 20b. Place of Disposition (Name of cometery, crematory or other place)
Montgomery Date 20c. Location - City or Town, State 20a. Method of Disposition February 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 12, 2006 Crematorium Inc. Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501 21. Signature of Funeral Service Licensee Skins M00803 Q 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alzheimer's Disease 10 Years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ending physician and use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical been signed by the ettending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 💢 No Month Year 4☐Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has lirector, page 2 s autopsy performed 1 Yes 2X No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this s after death.
I Director: After this of in by the funeral d 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 XNatural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a
To the Funerel I
completely filled 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D26259 February 9, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <u> Ava A. Kaufmann, M.D. 8218 Wisconsin Avenue #103 Bethesda, Maryland 20814-3107</u> Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 4 2006 Registrar

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Physician McGloal Examiner    Physician McGloal Examiner   Complete   Complet	Bal	Depar Depar Impor eny in		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave. Du	Home of undalk,	f Dundalk, Inc. Maryland 21222	
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243. Was an autopsy performed?   1		the a	/sic	1 Yes 2 No 4 Premant at time of death 5 Other (specify)		North Day Feat	
243. Was an autopsy performed?   1	<u> </u>	that ti ed by detac			23e. Did	tobacco use contribute to the cause of death?	
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25. Was case referred to medical examiner?  1   Yes   2   No	O O	The la le has age 2	ошо		auto	ppsy prior to completion of cause of death?	
The state of the s	₹ ital		e C	25. Was case referred to medical 26. Place of Dea		N	-
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Peristrar's Signature	Sion	endir sath. or: Af he fu	atic	2/ Accident investigation M 1 Yes 2 No			
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Peristrar's Signature	₹ iž	or Att	ıı	determined 288. Place of injury - At nome, farm, street, factory, office			
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30. Name and address of person who completed gause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Penistrar's Signature		E Hos 24 hc Fun etely	dica	(Check only 2   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	urred at the time,	, date and place, and due to the cause(s)	
30. Name and address of person who completed gause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Penistrar's Signature		To the with n To the	Me			29d. Date signed (Month, Day, Year)	-
30. Name and address of person who completed gause of death (Item 23a) (Type, Print)  State  31. Date filed (Month, Day, Year)  32. Registrar's Signature				D34652		Frbruger 7 2006	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	<del></del> ,	าอ		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	W)	1 / 2/1/12	-
Citate			100	2017	relary!	and divi	
				FEB 1 4 2006	/		

Amend item 8 per fh g852 2-17-06 vt.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** ohnson 0712 Ma 1140AM 200 /Medical 4e. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hogpeta 2 en If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Md) 7. Day, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last/birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2XF Director 03/<del>06/</del>1933 215-28-4984 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "naturel", or items 23a or 28a-f ehow other traumatic event, the Modical Examinar must be notified at Baltimore 1 XYes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21212 U.S.A. 814 Winston Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if liem 27 is marked other than 'any injury or other traumatic event, the Means ping. Elementary/Secondary (0-12) College (1-4or 5+) Nurse Assistant Medical 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Raymond D. Coles Ruby Barrett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 814 Winston Ave., Baltimore, Maryland Ernest Johnson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/18/2006 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Pk. Ceme. Baltimore, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Pert1. Enter the disease, or complication, the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Diverter **Physician** 01/2 /Medical resulting in death) Due to (or as a consequence of): Examiner 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transi -120 a Due to (or as a consequence of): the attending physicien Division of Vital Records, P.O. Box 68760, by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No this certificate has 1 ☐ Yes 2 100 filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Al within 24 hours after o To the Funerel Direct 4 - Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 006 2-1239 30. Name and a dress of person who completed use of death (Item 23a) (Type, Print) 14 11 5601 M 100 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 4 2006 books Registrar

DHMH 17 Rev 1/200

JUINSON WALTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 111 6

	1	For State Registrar	State of Ma	ryland /		ment of H		Mental Hy	giene (	006	04113
		Decedent's Name (First, Middle, Last)						2. Date of De	eath Day	V	3. Time of Death
Physiciar /Medica		Robin K:	Tohoso	n				Month 2		Year ZOOG	9:45 A M
Examine		a. Facility Name (If not institution, give s			41	. City, Town, or	r Location of Dea	th	4c. Cou	inty of Death	
	1	John Health BAUVICE	1 Care Cer	ter		Baltin	vore C	174			
Funeral	5	5. Social Security Number 6. Sex	7. Age	(In yrs. last b		Under 1 Year onths Days	If Under 24 Hrs Hours Min		rth	9. Birthp	lace (State or Foreign
Director		265-23-6816	M 2 <b>∑</b> F	46	Yrs.	Ontins Days	110013	Junel	7,1959	Flo	rida
P .		Usual Residence of Decedent		10c. City, To							Od. Inside City Limits
aryla ahov	_	10a. State 10b. County  MD Baltimo	+		en or Locati Essex					,	1 Yes 2 TNo
Ba-f	2		)Te								
	5	10e. Street and Number  17 Ridgemoor Ro	hec.			10f. Zip Code 2122	21		10g. Citizen	of What Cour	ntry?
of the death virtual virtual virtual	2				12 14/2-1			Coordy Voc or N		Race - Americ	en Indian
er de		11. Marital Status  1 □ Never Married 2 □ Married	12. Was Decedent E Armed Forces?		If Ye	s, specify Cuba	an, Mexican, Pue	Specify Yes or N no Rican, etc.)		Black, White,	
rs aff	DY L	3 Widowed 4 Vivorced	1 ☐ Yes 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,	10	Yes 2 No	Specify:		Spe	ecity:Whi	te
thou with the		15. Decedent's Edu		16	a. Decedent	's Usual Occup	ation		16b, Kind o	of Business/In	dustry
U 72 ni 72 n	Completed	(Specify only highest grade	completed)		(Give kini life. DO	d of work done i NOT use retired	durina most of w	orking			•
with the state of		Elementary/Secondary (0-12) 12th	College (1-4or 5+	-)	Disa	bled			N/A	A	
Hygir Hygir ant, I	0 0	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sun	name)	
Iryland 2 should be filed and Mental Hygi marked other matic event, I	0	Thomas J. Vinc	cent				F.Ela	ine Sh	ock		
lore, Marylan ges 1 and 2 should be t of Health and Mental if item 27 is marked or or other treumetic eve		19a. Informant's Name/Relationship (Ty	pe, Print)	19	b. Mailing A	ddress (Street	and Number or F	Rural Route Numb	er, City or To	wn, State, Zip	Code)
and 2 and 2 ealth a n 27 is		F.Elaine Shock	/ mothe:	r	16 F	venal	Road E	Baltimo	re MD	2122	1
Item other		20a. Method of Disposition		20b. Place	of Disposition	on (Name of ory or other place	ca)	Date	20c. Location	on - City or To	own, State
Pages Pages nent of int: # lt		1 ☐ Burial 2 ☑ remation 3 ☐ P  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	* 1	Cremato	·	16/06	Balt:	imore	MD
in the state of		21. Signature of Funeral Service License	e (i)	11		ame and Addre		1	-	7	_
Bal permi Depa Impo		A Terra	16000	elle	1 -	OO Ma	7 7 7 7 7	Balti	yrune:	ralHor	meofEssex
HE WASHINGTON	+	23a. Part1. Enter the disease, or complishock, or heart failure. List only of	cations that caused	he death.	not enter t	he mode of dyin	ng, such as cardi	ac or respiratory	HOEE ( arrest,	MD ZI.	Approximate
		shock, or heart failure. List only of Immediate Cause (Final	te cause on each line		/	1					Interval Between Onset and Death
Physician / /Medical		disease or condition resulting in death)	. <u>Mu</u>	1tole	_	10,000.	15				years
Examiner			Due to (or as a	consequence	B 01).						,
	E.	if any, leading to immediate	Due to (or as a	consequence	e of):						
ned ned	Examiner	Cause (Disease or injury									
al-tra	X	that initiated events resulting in death) Last	Due to (or as a	consequence	e of):						
	dicai		1								
687 fficate g phys	edic										
Box 68 leath certific: attending pl for use as t	2	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of						23d.	Date of deliv	ery
Beath atte	<u>C</u>	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t			topic pregnancy ther <i>(specify)</i>	/			Month	Day Year
Records, P.O. Box 61 The law requires that the death certific the has been signed by the attending p age 2 should be detached for use as i	Physician/Me	9 Unknown	9□ Unknown								
IS, P.	Dy E	Part II. Other significant conditions con	ntributing to death bu	t not resulting	in the unde	rlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to t	he cause of death?
rdS ruires n sign	O D	Stan IV SRC	of deci	Litus				1 🗆	Yes 2 ☑ 🗖	o 3 ☐ Prol	bably 4 Unknown
w require	Completed							24a. Wa	s an 2	4b. Were auto	opsy findings available
Rec	Ĕ.							рел	opsy ormed?	prior to co death?	empletion of cause of
Vital Records, sician: The law requires t certificate has been signe rector, page 2 should be o		25. Was case referred to medical					OS Place of D	1 Yes	2 46	1 🗆 Yes	2 □ No
Vision of Vita Attending Physician: or death. ector: After this certific. by the funeral director.	De C	examiner?	lospital:	. 2 D E D /	Outpatient	a□ DOA Oth		eath (Check only Home 5 Res		Othor (Speci	4.1
Physical distribution	0	27. Manner of Death	28a. Date of Injury (Month, Day		. Time of	28c. Injur	4 Mursing	28d. Describe			ry)
ding P	0	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	Year)	Injury		rk? ∣Yes 2 ∐ No				
Division of to attending Physical death. Director: After this in by the funeral di	Ica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home,	farm, street	factory, office		28f. Location	(Street and N	umber or Rur	al Route Number,
Div I or A after Direction by	Certification:	4 Homicide	building, etc	(Specify)				City or To	iwn, State)		
spita ours neral		29a. Certifier 1 Certifying Phy	sician: To the best o	f my knowled	ge, death or	curred at the tir	me, date and pla	ce, and due to the	e cause(s) and	manner as s	stated.
Division of Vital Re To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	(Check only 2 Medical Exami	ner: On the basis of and manner state	examination a	and/or inves	tigation, in my o	opinion, death oc	curred at the time	, date and pla	ice, and due t	o the cause(s)
o thi	Z	29b. Signature and title of certifier	00			29c. Licens	se number			igned (Month,	
->-0		Mill the	11-	3		DZ	7711		7-	10-	2006
	-	30. Name and address of person who co	mpleted cause of de	ath (Item 23s	) (Type Pri	nt)				/	
		Michele F. R. Ile	for mo	5.1 03	- 11	alli.	Rain	Ci.	la R	16	200 (.
Stat	e	31. Date filed (Month, Day, Year)	32. Popiikra	r's Signature		from the	Jag sie	J 17C	- D,	atoms	1110
Registra	- 1	FEB 1 4 26	06	1	has	ante s					
DHMH 17 Rev 1/200	01	40		(1007 A)	1						

		Unpend item#23a 1- State Registrar		•	Certificate			Reg. No	211116	04111
Physicia	an	1. Decedent's Name (First, Middle	i, Last)				2. Date of Dea		X Year	3. Time of Death
/Medic		Colleen E					Februar			1600
Examin	er	4a. Facility Name (If not institution				wn, or Location of Death	1		County of Death	
Funeral		17 Richmar Road 5. Social Security Number	6. Sex 7. Ag	e (in yrs. last b	irthday) If Under 1		8. Date of Birt (Month, Da	h Voorb	9. Birthp	lace (State or Foreigntry)
Director		218-72-0970	1□M <b>X</b> (X)F	48	Yrs. Months E	Days Hours Min.	Aug. 1	6,1	957 Ma	ryland
land		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Location				1	0d. Inside City Limi
ath with the Maryland 23s or 28s-f show	tor	MD Balti	more	Rei	sterstow	m				1 □ Yes 🏋 🏋
within 72 hours after death with the ene. then "natural", or Iteme 23s or 28s he Modicel Examilier must be moti	Funeral Director	10e. Street and Number			10f. Zip Co			10g. Cit	tizen of What Cour	•
e 23a	ral	200 Timber	Grove Rd.		10 14- 5	21136	Don't Von al No		U.S.A	
after dea or Iteme	Fune	11. Marital Status  XXNever Married 2 Marri	Armed Forces?			nt of Hispanic Origin? (S r Cuban, Mexican, Puert	o Rican, etc.)	•	Black, White,	
ours aff	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	-	1 ☐ Yes 🏋	No Specify:			Specify: Wh	ite
72 hour 'natural' dicel Ex	Completed	15. Decedent (Specify only highes		16	a. Decedent's Usual ( (Give kind of work of	done durina most of wor	rking		ind of Business/Inc	
permit. Pages 1 and 2 should be filed within Department of Health and Montal Hygene. Important: If Item 27 is marked other then any Injury or other traumatic event, Item 800ce.	Jup	Elementary/Secondary (0-12)	College (1-4or 5	5+)	life. DO NOT use	itcher			ate Hig minstra	_
other ent, I	Be Co	17. Father's Name (First, Middle, I	Last)		DIDPO		ne (First, Middle,			101011
Menta irked ific ev	ТоВ	Edward Aug	just Jones			Charlot	te Eli	zab	eth DeA	tley
and le ma		19a. Informant's Name/Relationsh		1	•	Street and Number or Ru				-
Health mm 27 ther tr		Charlotte E. J	ones/Mothe		00 Timber of Disposition (Name	Grove Rd.	; Reist		stown, Mocation - City or To	
nt of h		1 Durial 2000 remation		cemet	ery, crematory or othe	ory Inc. 2				
artme ortani Injury		4 Donation 5 Other (Sp. 21. Signature Faneral ryice L		Mecr		Address of Facility EC				
Depa Impo any Ir		Michael	Tomm			eistersto				
/Medical /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading to immediate	b	a consequence	∍ of):					
ate be executed hysicien and the burial-transit	lical Examin	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence	<b>3</b> of):					
The law requires that the death certificate be executed ste has been signed by the ettending physicien and page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deal	h 3 Ectopic preg 5 Other (speci				23d. Date of delive Month	ory Day Year
signed to detect the detect of	by P	Part II. Other significant condition	ins contributing to death b	ut not resulting	in the underlying caus	se given in Part I.	23e. Did to	obacco (	use contribute to th	ne cause of death?
been signatured by should b							101	/es 2	Mo 3 Prob	ably 4 □Unkno
The law i	Completed						24a. Was autop		24b. Were auto	psy findings availa npletion of cause
ician: The certificete rector, pag							1 Yes	2 □ No	death.	2 No
E = 0	o Be	25. Was case referred to medical examiner?  1,	Hospital:	ent 2 ER/O	Outpatient 3 DOA		th (Check only o		C17704 (C	\ C
Sicia	ို	27. Manner of Death	28a. Date of Injur			Other: 4 Nursing H	28d. Describe h	ow inju	ry occurred	// Scene
Physician: er this certific eral director.		1 □ Natural 5 □ Pending 2 □ Accident investig	jation Ind 2/10/06		0.4	Work? 1 □ Yes 2 ∏No	unk			
ding Phys n. After this funeral di			ined 28e. Place of Injuried	ury - At home, c. (Specify)	farm, street, factory, o	office	28f. Location (S City or Tox	Street ar	nd Number or Rura 9) 17 Richma	r Rd. Apt.
ding Phys n. After this funeral di		3 ☐ Suicide 6 € Could n 4 ☐ Homicide determi	building, etc	oori donco			Owings Mi	11s,	MD	
ding Phys	Certification:	3 ☐ Suicide 6 【 Could n 4 ☐ Homicide determi	Found: re							
Hospital or Attending Phys 4 hours after death. Funeral Director: After this iely filled in by the funeral dii	Certification:	3 Suicide 6 Could n determi	Found: regPhysician: To the best of Examiner: On the basis of	of my knowledg	ge, death occurred at t ind/or investigation, in	the time, date and place my opinion, death occu	, and due to the or rred at the time,	date and	) and manner as st d place, and due to	ated. the cause(s)
Hospital or Attending Phys 4 hours after death. Funeral Director: After this iely filled in by the funeral dii		3 Suicide 6 Could in determine 4 Homicide 29a. Certifier (Check only 2 Medical E	Found: regPhysician: To the best of Examiner: On the basis of and manner sta	of my knowledg	nd/or investigation, in	the time, date and place my opinion, death occu icense number	rred at the time,	date and	) and manner as side place, and due to the signed (Month,	the cause(s)
or Attending Physitie death. Director: After this in by the funeral director	edical Certification:	3 Suicide 4 Homicide  6 Could in determine  29a. Certifier (Check only one)	Found: regPhysician: To the best of Examiner: On the basis of and manner sta	of my knowledg	nd/or investigation, in	my opinion, death occu	rred at the time,	date and 29d. Da	d place, and due to	Day, Year)

DHMH 17 Rev 1/2001

			1- State of Maryland / [ Registrar	Department of Health and Meni Certificate of Death	tal Hygiene	04115
	Physici /Medic		1. Decedent's Name (First, Middle, Last)  DAY ID TOYCE	A	Date of Death  Month Day Year  EBRUARLY 6 200	3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)  NORTH WEST KOSPITAL	4b. City, Town, or Location of Death RANDALLS	TOWN 4c. County of Dea	ALTIMORE
	Funeral Director		102-22-7742 // 31	thday) If Under 1 Year If Under 24 Hrs. 8. C. Months Days Hours Min.	Date of Birth 9. Birth M. 1941 9. Bir	rthplace (State or Foreign NNESOTA
	how how		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town	n or Location		10d. Inside City Limits
	the Ma	ecto	MD BALTIMORE I	REISTERSTOWN	10g. Citizen of What C	1 Tyes 2 No
	3a or 3	DIE	705 COCKEYS MILL ROAD	21136	Tog. Citizen of What Ci	USA
036	be filed within 72 hours after deeth with the Maryland hal Hygiene. Id other then "natural", or lieme 23a or 28a-f ehow event, I'm Mudical Exardi.ar frunt be mudified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 ☑ Yes 2 □ No WW I I I' Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar 1   Yes 2 No Specify:	Yes or No- n, etc.) 14. Race - Am Black, Whi	
21215-0036	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business	s/Industry
212	2 should be filed within and Mental Hygiene. Ie marked other then eumatic event, the Mental count, the Mental count, the Mental count, the Mental count, the Mental count coun	Somp	Elementary/Secondary (0-12) College (1-4or 5+) 2	NER .	VENDING MA	CHINES
and	d be filed intal Hygie ed other	Be	17. Father's Name (First, Middle, Last)  DANIEL	JOYCE MARY	st, Middle, Maiden Surname)	(UNKNOWN)
Maryland	should and Me mark sumation	오	19a. Informant's Name/Relationship (Type, Print)	. Mailing Address (Street and Number or Rural Ro		Zip Code)
	1 and 2 Health om 27 I			705 COCKEYS MILL ROAD -  1 Disposition (Name of Date	REISTERSTOWN,	
Baltimore,	Pages nent of int: If Its		1 N Burial 2 Cremation 3 Removal from State	ry, crematory or other place) ORE HEBREW CEM. 02/12/2		STOWN, MD
Balti	permit. Pages 1 and 2 should by Department of Health and Menta Importent: If Item 27 is marked any Injury or other treumatic espice.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility SOL 8900 REISTERSTOWN RO	LEVINSON & BROS	
I			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac or res		Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence	-4).		
	Examiner	_	Sequentially list conditions b. CLOSTRIDIU	M DIFFICILE COL	-1715	
V	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	orj:		
68760,	icate be executed physicien and the burial-transit	dical Exe	resulting in death) Last  Due to (or as a consequence	of):		
	ndificate ng phy s as the		IF FEMALE:			
P.O. Box	Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and rail director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of de Month	elivery Day Year
rds, P	w requires that been signed b should be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in		23e. Did tobacco use contribute t	
Division of Vital Records,	The law re cate hes be page 2 sho	Completed			autopsy prior to performed? death?	autopsy findings available completion of cause of s 2 No
Vita	elcian: certific irector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Department 2 ER/Ou	26. Place of Death (Ch		
ion of	nding Phy th. : After this s funeral d	tlon: To	27. Manner of Ceath 28a. Date of Injury 28b.		5 Residence 6 Other (Specific Rescribe how injury occurred	өспу)
Divis	al or Atters a state dead	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, fa building, etc. (Specify)		Location (Street and Number or R City or Town, State)	Rural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge of examination and manner stated.	e, death occurred at the time, date and place, and of door investigation, in my opinion, death occurred at	fue to the cause(s) and manner a the time, date and place, and du	as stated. ue to the cause(s)
)	To the To the comp	Ž	29b. Signature and title of certifier	29c. License number D 54352	29d. Date signed (Mon	nth, Day, Year)
	6		30. Name and address of person who completed cause of death (Item 23a)  NORTHWEST HOSPITAL SHOL	(Type, Print) MIRCEA TODO OLD (OURT ROAD)		
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 4 2006 32. Registrar's Signature	Agail)		

			1 - For Stete Registrer	State of Man		artment of F rtificate of		• -	ene 1. No. 006	04116
	Physici /Medi		1. Decedent's Name (First, Middle, Last EDWARD KE	TTERIN	GHAM			2. Date of Death Month FEBRUARS	Day Year	2.2004
F	Examir	ner	4a. Facility Name (If not institution, give HARBOR HOSPI		NTER		r Location of Dea	th	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Se 284-36-8524	7. Age (/	n <i>yrs. last birthday)</i> 64 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Q Ri	rthplace (State or Foreign ountry)
	/land		Usual Residence of Decedent  10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limits
	e Man	ctor	MD Anne Aru	nde1	Glen Bur	nie				1 ☐ Yes 2 ☒ No
	th with the	ai Dire	10e. Street and Number 144 Alview Terrac	e		10f. Zip Code 21060			Citizen of What Co.S.A.	ountry?
9036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinating the notified at	d by Funeral Director	11. Marital Status  1 ☐ Never Married 2☐3Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba 1 Yes 2500No	lispanic Origin? (s an, Mexican, Puel Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify: Wh	ite, etc.
Maryland 21215-0036	ithin 72 h	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo d)	orking	6b. Kind of Business	•
d 21	filed w Hygier ther th		17. Father's Name (First, Middle, Last)	4	Elect	rical Eng		me (First, Middle, Ma	Northrop	Grumman
ılan	should be ind Mental marked c	To Be	Ralph Edward Kett	eringham				V. Koehr		
	and 2 sho		19a. Informant's Name/Relationship (Ty Mrs. Therese Kett	•				dural Route Number, G Glen Burn		
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: if item 27 is any injury or other tra ange.		20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	1	Chesapea	matory or other plac ke Cremat	tion 2-15	5-2006 s	c.Location - City o	le, MD
Ball	Depart Depart Import any in		21. Signature of Funeral Service License					ingleton F Glen Burni		
	_		23a. Part1. Exter the disease, or complishock, or heart failure. List only or	cations that caused the	0-1001					Approximate
Ž.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a co	ophic L	ateral	Sclero	نا ک		Interval Between Onset and Death
	Examiner	ıer	if any, leading to immediate	Due to (or as a co	этэециелсе о!).					
<u>,</u>	icate be executed physicien and s the burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of);					
68760,	ate be hysicie he bur	edical								
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S, D	res that signed by be deta		Part II. Other significant conditions con	tributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.			o the cause of death?
200	w require	ieted	Hypertension					24a. Was an		robably 4 🗹 Onknown
al Re		Completed by	Diabetes Melli-	HU.J				autopsy performe 1 Yes 2	death?	utopsy findings available completion of cause of 2 No
<b>\frac{1}{5}</b>	rsicie s certii directo	To Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatien	t 3 DOA Oth		ath (Check only one) Home 5 ☐ Residence	o 6 □Other (See	soif il
Division of Vital Records, P.O.	ding P. I. After ti funera		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Ye	28b. Time of	28c. Injun Work		28d. Describe how		city)
Divis		Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stre Specify)	eet, factory, office		28f. Location (Stree City or Town, S	et and Number or R State)	ural Route Number,
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Medicai (	29a. Certifier 1 Certifying Phys cone) 1 Medical Examin	ician: To the best of m ler: On the basis or exa and manner stated.	amination and/or inv	occurred at the timestigation, in my of	ne, date and place pinion, death occu	e, and due to the caus urred at the time, date	se(s) and manner a and place, and du	s stated. a to the cause(s)
) ,	To the Within 2 To the	×	29b. Signature and title of certifier  Rayarst Pale	pu MD		29c. License		29d Fe	Date signed (Mon	th, Day, Year)
10	) [		30. Name and address of person who co		(Item 23a) (Type,	The Street W	or Br	Himore	Mo	2225
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 4 21	32. Registrar's	Signature	150				
DHN	MH 17 Rev 1/20		· ~ \ T # 7(	JUU July	5 19	1842/				

			1 - For State Registrar	State of Maryland	/ Depa		Health and M	lental Hygi	•	04117
*	Physici /Medie		Decedent's Name (First, Middle, Last)	FRANKIE LABE				2. Date of Death Month		3. Time of Death 2:15 A M
0	Examir		4a. Facility Name (If not institution, give stre Crofton Convalesce 5. Social Security Number 6. Sex				ofton  If Under 24 Hrs.	9 Date of Birth	4c. County of Dea	nde1
	Funeral Director		441-16-1552 1□ M Usual Residence of Decedent	²₹F 86	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Apr 16,	Year) 9. Bin 1919 Ok	thplace (State or Foreign buntry)  lahoma
	the Marylar 28e-f show	Director	Maryland 10b. County Maryland Anne Aru	nde1	own or Lo	Se	vern			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	s 23e or		8465 New	Cut Rd.,		10f. Zip Code	21144		g. Citizen of What Co USA	
036	should be filed within 72 hours after death with the Maryland of Mental Hyglene.  marked other than "natural", or liems 23e or 28e-f show marked other than "natural", or liems 25e or 28e-f show maile event, the Madical Examinar mast be notified at	by Funerai	11. Marital Status 12.  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of F If Yes, specify Cuba 1 ☐ Yes 28 No	dispanic Origin? (Spe an, Mexican, Puerto Specity:	city Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
Baitimore, Maryland 21215-0036	within 72 ho	Completed by	15. Decedent's Educati (Specify only highest grade co Elementary/Secondary (0-12) 12	College (1-4or 5+)	(Give life. l		nation during most of working d) e Assistar	ng	Kresge an Dept. St	d Korvette's
yland 2	e d fa la	To Be C	17. Father's Name (First, Middle, Last) Frank	2			18. Mother's Name LaBe11	(First, Middle, M	aiden Surname)	
, Mar	s 1 and 2 should of Health and Men item 27 is marke other treumatic		19a. Informant's Name/Relationship (Type, Mary Elizabeth Krame	er (Daughter i	.n 1a	w) 8465	New Cut F		City or Town, State, 2	
Imore	permit. Pages 1 Department of H Important: If iter any injury or oth		20a. Method of Disposition 1 □ Burial 2 Ø Cremation 3 □ Rem '4 □ Donation 5 □ Other (Specify)	Bay		sition (Name of natory or other place Cremator			Oc.Location-City or Baltimore,	
ga	permil Depar Impor any in		21. Signature of Fune al Service Licensee		N 1	30 E. Fo	olyniak Fi rt Ave l	Balto	Md. 2123	
	Priysician /Medical Examiner	ner	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one of the complete shock, or heart failure. List only one of the complete shock of the comple	Due to (or as a consequence	uluu ee of):	er the mode of dyin	g, such as cardiac o	r respiratory arres	st,	Approximate Interval Batween Onset and Death
8/60,	icate be executed physician and s the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequenc	e of):					
O. BOX 6	fhat the death certificated by the attending phydetached for use as the	Physician/Me	in the past 12 months?	If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d. Date of deli Month	ivery Day Year
ras, r	w requires fhat been signed b should be dete	by	Part II. Other significant conditions contrib	uting to death but not resulting	j in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?
	The law ate has b page 2 sl	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of
	ding Phy n. After this funeral d	ıtlon: To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hosp  27. Manner of Death 1 Natural 5 Pending 2  Accident investigation	1   Inpatient 2   ER/C	Outpatient Time of Injury	28c. injury Work	4 A ursing Hom		ce 6 Other (Spec	ify)
=	the Hospital or Attendiin 24 hours after death. the Funeral Director: A pletely filled in by the fu	Certification:	2 Cuiside 6 Could not be	8e. Place of Injury - At home, building, etc. (Specify)	farm, stre		_	8f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dire.	edicai	29a. Certifier (Check only one) 1 Certifying Physicia 2 Medicel Examiner:	n: To the best of my knowled On the basis of examination a and manner stated.	ge, death and/or inv	occurred at the timestigation, in my op	ne, date and place, a pinion, death occurre	nd due to the cau d at the time, date	se(s) and manner as e and place, and due	stated. to the cause(s)
1	With Som	Σ	29b. Signature and title of certifier			29c. License	8958	290	d. Date signed (Month	, Dey, Year)
5	C		30 Name and address of person who completed Supplement	6 Sidhu 20	(Type, F	Som M	ighung s	w oli	n Burni	c MD2061
	Sta Registra		31. Date filed (Month, Day, Year) FEB 1 4 2006	37/Registrar's Signature	A DE					f

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AM **Physician** OUTSONOURIS ebruary Zoula. /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.

Pays Hours Min. Birthplace (State or Foreign Spuntry)
 TRECE 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex **Funeral** 102M 2□F Days 38 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f show ury or othar traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Completed by Funeral Director baltincore City 10g. Citizen of What Country? 10e. Street and Number USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) a1/OR 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 DU ANCZINA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of important: if any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) AWN CEMERLY 22 Name and Address of Faulity
Bradin
LI34 WITTOW 21. Signature of Funeral School Licensee DrINA 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of) by Physician/Medical Examiner ng physician and as the burial-transit To the Hospital or Attanding Physician: The law requires that the death certificate be execu Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Hospital: Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne I Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 6 ☐ Could not be 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours after To the Funeral Direc 4 🗍 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Chack only one) 29b. Signature and title of certifier ne and address of person who completed cause of death (Item 23a) (Type, Print) ar) Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene 1- State RegisAmend ITem #5 Per FH C853 3/14/96 if impate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** WILLIAM THORN KISSEL JR. 12:545P FEB 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 601 BRIGHTWOOD CLUB DRIVE LUTHERVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02/06/1920 Funeral 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours Min 1 M 2□ F NEW YORK Yrs. <del>3047</del> 86 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 BRIGHTWOOD USA or Iteme 23e CLUB DRIVE 21093 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. a filed within 72 hours after de it Hygiene. Other than "naturel", or Item 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Š Specify: WHITE 3XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w
Department of Health and Mental Hygien
Importent: If tiem 27 Ie marked other th
eny injury or other treumatic SCULPTOR SCULPTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM THORN KISSEL FRANCES DALLET 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL C. KISSEL(SON) 106 EAST 85th St. APT. 3-S N.Y, N.Y. 10028. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State THOMAS GARRISON 02/15/06 OWINGS MILLS, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility HENRY W. JENKINS & SONS CO. 16924 YORK RD MONKTON, MD. YORK RD MONKTON, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pneumoni **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ sign I be NIDE 1 🗌 Yes 3 Probably 4 □Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of ause of death? autopsy performed? 2 100 1 Tyes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 ER/Outpatient 1 Inpatient 3□ DOA this 27. Manne of Death 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident I Director: A 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of car 29d. Date signed (Month, Day, Year) 00034988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID ROBERTS M.D. 10753 FALLS RD. SUITE 255 LUTHERVILL, MD. 21093. 31. Date filed (Month, Day, Year) Registrar's Signature State 4 2008 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#20b,perFH,0852,2/14/06 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. UU h Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 11:09 AM **Physician** February 2006 Kino /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Randallstown Northwest BALTIMORE Hospital Center If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth May 14, 1920 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1 M 2 □ F 216-12-3656 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b County 10a State item 27 is marked other then "naturel", or items 23s or 28s-1 show other treumstic event, the Modical Examinar must be notified at 1 ☐ Yes 2 ☑ No RANDALLSTOWN Director BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21133 3608 RUSTY ROCK ROAD 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel; or item eny injury or other treumatic event, it a Medical Exercical once. 1 ☐ Never Married 2 🏋 Married WHITE 1 ☐ Yes 2 X No Specify: Specify. ģ 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRINTING PRINTER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **GAMPEL** KING KATIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20 INDIAN PONY COURT - OWINGS MILLS, MD 21117 SHERRY UNGER / DAUGHTER 20b. Place of Disposition (Name of cametery, crematory or other place) POST 167-2/13/2006 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State JEWISH WAR VETERANS +02/12/2006 ROSEDALE, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Scette 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final <24 hour a Anoxic **Physician** brain disease or condition resulting in death) /Medical Examiner electrica cardiac arrest Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien and for use as the burial-transit Profound anemia Gastrointestinal with possible retroperitoneal hemorrhage Physiclan/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 2 DNO fibrillation 3 Probably 4 Unknown 1 🗌 Yes Completed Type II diabetes mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Agnogenic myeloid metaplasia
25 Was pase referred to medical
examiner?
Hospital: Magnification 300 1 ☐ Yes 2 ☐ No or Attending Physician: 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A investigation 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospitei 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier February 9, 2006 028462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Randallstown, Maryland 21133 Northwest Hospita Center 32 Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 4 2006 Registrar

			1 - For State Registrar	State of Mary	-	artment o rtificate d			jiene	06	04	21
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			Greater Baltimo  5. Social Security Number 6. S				owson ear   If Under 24 F	dre la a		ltimo		
	Funeral Director			ex 7. Age (In	yrs. last birthday, 69 Yrs.	Months Da		Hrs. 8. Date of Birth (Month, Day Dec 27,	1936		place (State of http:// Jerse	
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	ath w		4630 Keswick Road			212			US	A		
	ltem merri	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	n U.S. 13.	Was Decedent of Yes, specify Control	of Hispanic Origin? Cuban, Mexican, Pu	(Specify Yes or No- ierto Rican, etc.)		ice - Americ ack, White,		
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Baltimore,	ges I If of F If ite or ot		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □		b. Place of Dispo cemetery, cre				20c. Location			
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Ba	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Begartment of Health and Mental Hygiene. Begartment of Health and Mental Hygiene and Health and 1884-1 show any Injury or other traumatic event, the Medical Examinar must be notified at Once.		21. Signature of Funeral Service (Icen	eju	(	Crematic 299 Fred	on Societ derick Ro	y Of Mary ad Baltimo	land In	nc. arylar	nd 212	28
'	Physician and was executed by sician and was executed the private transit to be private and th	ai Examiner	23a. Part1. Enter the disease, or composition shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infliated events resulting in death) Last	one cause on each line.	YM 40 (a ) sequence of):	1 0	dying, such as card	liac or respiratory arri	95t,	ó	Approximatinterval Bet onset and I	ween
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J	s mat ned b e deta	by Ph	Part II. Other significant conditions co	ontnbuting to death but not	resulting in the u	nderlying cause	given in Part I.	23e. Did tob	acco use cor	tribute to th	ne cause of d	eath?
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0			Marie Chat	ho	6701	N Oc	andro St	Betting	1,1	21	out	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death Month 1. Decedent's Name (First, Middle, Last) Year Day **Physician** Zora M. Lawless Feb. 2006 16:45 M 11, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Hospital Center Carrol1 Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M XX F 217-26-6107 94 Director Jan. 28,1912 Virginia Usual Residence of Decedent with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits rthen "naturel", or items 23a or 28a-f ehow the Medical Examiner must be notified at 1 ☐ Yes XXNo Carrol1 Sykesville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7309 Second Ave. 21784 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 American 1 ☐ Yes XXNo Specify: à XXWidowed 4 ☐ Divorced Indian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hyglene. ant: If item 27 is marked other then ury or other traumatic event, Ita Ms Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pidge Branham Rena Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Lawless / Son 1805 Connolly Dr.; Westminster, MD 21158 20b. Place of Disposition (Name of cometery, crematory or other place)
Glen Haven 20a. Method of Disposition 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State permit. Page Depertment of Important: If eny injury or once. 4 □ Donation 5 □ Other (Specify) 2/15/06 Glen Burnie, MD Memorial Park 21. Signature of up rel Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atheroscherof Coroner Vestela Das Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence off Examiner Hospital or Attending Physicien: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760, physicien Physician/Medical the IF FEMALE: esn 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) the be detached 9 Unknown 9 DUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 -No Division of Vital the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 P/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification; To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After t 5 Pending 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A 2 Accident investigation 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 — Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifian Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Perto J. Mans 032882 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Contra Dr. Reinfantary, Ml. 117 15 31. Date filed (Month, Day, Year) FEB 1 4 2006 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 2:39P M HENRY V. LINDEMAN, SR. FEBRUARY 11, 2006 /Medical 4c. County of Death Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Saint Joseph Medical Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral №** M 2 F Director MARYLAND 10/11/1933 219-28-1230 72 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State Worle or 28a-f show 1 ☐ Yes 2X No BALTIMORE TOWSON Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code WIT r than "natural", or iteme 23a or the Medical Examinar must be deeth v 1619 YAKONA ROAD 21286 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 □ No If Yes, Give Year or Dates: KOREAN 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify ģ WHTTE 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DUPONT PAINT TINTER 12TH GRADE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit iment of Heelth and Mental H tent: If item 27 is marked other. CLARISSA ANDERS HARRY RICHARD LINDEMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1619 YAKONA ROAD TOWSON, MD 21286 DOROTHY G. LINDEMAN/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of F-importent: if its eny injury or ott page. 1 ⊈Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 2/15/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tur of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON, MD Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CEREBELLAR/BRAIN STEM CEREBRAL VASCULAR /Medical Due to (or as a consequence of): Examiner ACCIDENT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and the burial-transit or Attending Physicien: The law requires that the death certificate be executed LUNG CANCER Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. I 1 Yes 2 No 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ۾ 3 Probably 4 Unknown 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No 2 No 1 ☐ Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 🛣 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Oescribe how injury occurred Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours efter death. To the Funerel Director; A completely filled in by the fu 2 Accident investigation 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 17695

Registrar

State

OBALL)

7601 OSLER DRIVE, TOWSON, MARYLAND 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

32. Registrar's Signature

31. Date filed (Month, Day, Year)

FEB14

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	Physici	an	Decedent's Name (First, Middle, Last							2. Date of Dea Month	ath Day	Year	3. Time of Deat	h
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	Funeral		5. Social Security Number 6. Si	ex (). Age	(In yrs. last birt	hday) If Under	r 1 Year	If Under 2		8. Date of Birt	h		place (State or For	eign
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	put &		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location						1	Od. Inside City Lin	nite
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	ems ?	iner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S.	13. Was Dece	dent of Hi	spanic Orig	gin? (Spe , Puerto l	cify Yes or No- Rican, etc.)	- 14. Ra	ace - Americack, White,		
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Records,	w requir been si should	Completed												
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Vital	(0 -	e C	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only d	20 No	1 ☐ Yes	20No	
Ţ	S O	To B	examiner?	Hospital: 1 Inpatie	nt 2 ER/Ou	tpatient 3 DC	Othe	ac l		ne 5 Resid	Carlo Service	ther (Specif	y)	
n of			27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of Injur (Month, Day			28c. Injury Work			28d. Describe h	now injury occu	ırred		
sio	Attending r death. ector: After y the fune	icati	2 Accident investigation 3 Suicide 6 Could not be		Abb 6-	М		Yes 2□N		206 Laurtian /6	Carren a a second a force	-barrer D	1 Danie Alizabe	
Division		Certification:	4 Homicide determined	28e. Place of Inju building, etc	ory - At nome, tail or (Specify)	rm, street, factor	y, office		4	City or Tow		nber or Hura	il Route Number,	
_	To the Hospital or within 24 hours after to the Funstal Direction Completely filled in I		29a. Certifier Certifying Ph	ysician: To the best of	of my knowledge	, death occurred	at the tim	ne, date and	d place, a	and due to the	cause(s) and m	nanner as s	tated.	
	he Ho n 24 ł he Fu pletely	Medical	(Check only 2 Medicel Exen	niner: On the basis of and manner sta	examination and ited.	d/or investigation	, in my op	oinion, deat	th occurre	ed at the time,	date and place	, and due to	the cause(s)	
		Σ	29b. Signature and title of certifier			29	c. License	number			29d. Date sign	ed (Month,	Day, Year)	
,	12		"hour				0	2059	345	3 F	ebrua	ry 10	2006	
	·		30. Name and address of person who	completed cause of de			1. 6	COP RI	De st	202 R	. [4	PAS	12029	
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature	BIVD G8	264 N	rut 131	A STORY	yeus or	and smore	100	101257	
	Regist		FEB 1 4 2	2006	was St.	Sparke	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death LAWHORN Day Month **Physician** HAROLD 7.50 PM Februcury 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore center Tarbor HUSPITAL Bultimore 8. Date of Birth (Month, Day, Year) Sept. 27,1944 If Under 1 Year If Under 24 Hrs.

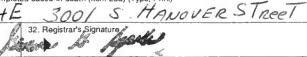
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 ☐ F 212 42 8298 61 Director Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location "naturel", or Items 23a or 28a-f show 1 ☐ Yes 2 👿 No Director Marvland Howard Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel", or Items 23e or 2, any injury or other treumetic event, the Medical Examples once. U.S. 8528 Starch Woods Drive Apt. 1B 20763 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) Truck Driver Baltimore City 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Miller Cletus Lawhorn ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Philip Lawhorn / son 2137 Kimrick Place Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Elkridge, Maryland \* 4 □ Donation 5 □ Other (Specify) Meadowridge Mem. Park 2/15/2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. nomercul erome 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Port1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ongestive Heart **Physician** /Medical Examiner potension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last attending physician a for use as the burialof Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown s been signed by the should be detached 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division To the Hospital or Attending 5 Pending investigation 1 Naturai death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \( \text{Homicide} \) within 24 hours after To the Funerel Dire Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar

MING 31. Date filed (Month, Day, Year) FEB 1 4 2006

29b. Signature and title of certifier



30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month Year Margaret Anna Lycett 1:35 P. February 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Genesis Healthcare Franklin Woods Baltimore Baltimore 8. Date of Birth Nov. 17, 1921 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days New York 1 M 2 XF Months Hours Min. 215 12 1130 84 Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Baltimore Baltimore Director Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō U.S. 8509 Woodfall Road 21236 items 23a Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 ☐ Yes 21 No Specify: Specify: White ò If Yes, Give Year or Dates: 3 XWidowed 4 ☐ Divorced "naturel" Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 5th Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be i and Mental I Frederick Fromme Margaret Burns ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy Brogley / Daughter f Health 8509 Woodfall Road Baltimore, Maryland 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, Slate 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: if eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 2/10/2006 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 ramertuselle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** FIROMODIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physicion: The law requires that the death certificate be executed and physicien ar Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 9 3 Probably 4 Unknown should I Disorder 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed this certificate 2□ No 1 Yes 2 No 1 Yes director 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Najural 5 ☐ Pending death. 2 Accident investigation М 1 Tes 2 No i Director: / 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours efter of To the Funeral Direct completely filled in by 4 Homicide the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signalure and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MM D53462 ss of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 7845 Road 6 len Burnie MD 21061 DAKWOOD a m 32. Registrar's Signature State Registrar 1 4 2006 FEB

			For State	State of Maryland	•			d Mental H	ygiene	0000	01.107
			Registrar  1. Decedent's Name (First, Middle,	( act)	Cen	ilicate	of Death	2. Date of	Reg. No.	. UUO	3. Time of Death
	Physicia	an	1. Decedent's Name (1 list, Middle,					Month	Day		11:55 P M
	/Medic Examin		4a. Facility Name (If not institution,	Bertram Levin  give street and number)	ie .	4b. City, To	wn, or Location of [	<u>Febru</u> Death		County of Dea	
	LAGITITI	CI		ilson Avenue			Rockvi1	le.		Mor	itgomery
	Funeral			6. Sex 7. Age (In yrs. Ia 1 ☑ M 2 ☐ F		If Under 1 \			Birth Day, Year)	9. Bir	thplace (State or Foreign ountry)
	Director		119-03-0378 Usual Residence of Decedent	86	Yrs.			May 1		19	New York
	and ow	1	10a. State 10b. County	10c. City,	Town or Loc	ation					10d. Inside City Limits
	Mary Feb	ţ	Maryland Mo	ontgomery			Rockvil1	P			1 X Yes 2 □ No
	or 286	Director	10e. Street and Number	/II C G O MC I y		10f. Zip Co			10g. Citi	izen of What C	ountry?
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	er de	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	i. 13. W	/as Deceden Yes, specify	t of Hispanic Origin Cuban, Mexican, F	? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Am Black, Whi</li> </ol>	
3	hours after death with the Maryland turet, or flems 23a or 28e-f ehow al Exart at must be codified at	by F	1 ☐ Never Married 2 ☐ Marrie 3 🏿 Widowed 4 ☐ Divorced	ed 1727 Yes 2 □ No If Yes, Give WWII Year or Dates: Kore a		☐ Yes 2🏋	No Specify:			Specify:	· · ·
9200-91212	2 hou ature cal E	ted	15. Decedent	s Education	16a. Decede	ent's Usual C	ccupation		16b. Ki	ind of Business	White Undustry
212	within 72 ene. then "nai he Medic	ple	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give k life. D	O NOT use	done during most of retired)	r working	II.	S. Dena	artment of
	filed wil Hygien other th	Completed		4		Feder	al Execut			Jus	tice
ב	be fill d oth	Be	17. Father's Name (First, Middle, L				18. Mother's	Name (First, Midd		ŕ	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylar if Heelink and Mental Hygiene. If Heelink and Mental Hygiene than "naturel", or tlems 23a or 28e-f ehow tithen 27 is marked other then "naturel", or tlems 23a or 28e-f ehow other traumatic event, the Medical Example at minist be indiffed at	ဥ	19a. Informant's Name/Relationsh	Benjamin Levine	10h Mailin	Addrage /S	treet and Number of			kowitz	Zin Code)
Σ	d 2 sho		Neil Levine/				Charen La				
<u> </u>	s 1 end Heelth Item 27 other tr		20a. Method of Disposition	20h Pla	ace of Dispos	ition /Name	of	Date		ocation - City or	
Ë	Pages nent of int: if it iny or o		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State Nor	metery, crem Deck Memoi	ial P	ark 1	ebruary 3, 2006		lnev l	Maryland
altimore,	permit. Pages Department of Important: if it eny injury or o	1	21. Signature of Funeral Service L		22.	Name and A	ddress of Facility	Robert A.	Pump	hrev Fu	ineral Home/
m _	88 5 8		Ven	) June 10033	35	Rockvi	lle, Inc. lle, Mary	1300 wes	50-28	05	Avenue
			23a. Part1. Enter the disease, or of shock, or heart failure. List of	corpolications that caused the death.	Do not ente	r the mode o	of dying, such as ca	rdiac or respirator	arrest,		Approximate Interval Between Onset and Death
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	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						
		-	Sequentially list conditions,	b. Due to (or as a consecue	anga offi	-					
	uted insit	mIne	any, leading to the rediate cause. Enter Underlying Cause (Disease or injury								
Ć	te be executed ysicien and ie burial-transit	Examiner	that initiated events resulting in death) Last	C Due to (or as a conseque	ence of):						
	± 5 €	Cal		d							
89	that the death certifica ed by the attending ph detached for use as th	Med	IF FEMALE:								
Вох	ath ce	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnan 1☐Live birth 2☐Fetal o	death 3□	Ectopic preg				23d. Date of de Month	Blivery Day Year
	he de the a	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at time of dea 9☐ Unknown	ath 5⊔	Other (spec	fy)		- 1		
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ds	uires n signe	d by						1	☐ Yes 2	12 No 3 □ F	robably 4 Unknown
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ž.	hysician: The lav his certificate has I director, page 2 :	Completed						— all pe	itopsy informed? s 2 🔯 No	death?	completion of cause of s 2 No
ita i	ertifice ctor, p	Bec	25. Was case referred to medical examiner?				· · · · · · · · · · · · · · · · · · ·	Death (Check on			
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<u>&gt;</u>	i or A effer Dire	Certification:	4 Homicide determine	building, etc. (Specify)	)	ot, lactory, c			Town, State		
	To the Hospitel or Attenwithin 24 hours efter deat To the Funeral Director: completely filled in by the		29a. Certifier 1 X Certifying	Physician: To the best of my know	vledge, death	occurred at	the time, date and	place, and due to t	he cause(s	) and manner a	is stated.
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19	X			who completed cause of death (Item			#4.100 0	- the - d -	Me 1	and 201	017_70/7
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			For State Registrar	State	of Marylar	•	artment of H			iene og. No. 006	04128
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2	168.5		3107 Greenhill		7 4 //	1	E of Under 1 Year	dgemere If Under 24 Hrs.	D. D. L. of Dist.	Baltimo	
	Funeral Director		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. 75	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) C	thplace (State or Foreign ountry)
30			212-28-3450 Usual Residence of Decedent		73				Dec. 14	1,1930 M	aryland
	yland		10a. State 10b. County		10c. Ci	ity, Town or Lo	cation				10d. Inside City Limits
	B Ma	cto	Maryland I	Baltimore				Edgemere	2		1 ☐ Yes 24(2)No
	₽ 22 B	Director	10e. Street and Number				10f. Zip Code		1	0g. Citizen of What C	ountry?
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36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itema 23e or 28e-1 show aumatic event, ite Medical Exam art must be notified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marria 3 ☑ Widowed 4 ☐ Divorced	Armed F 1 ☐ Yes If Yes, G	2 ⊊No live	İ	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	Rican, etc.)	14. Race - Am Black, Whi	te, etc.
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2	r than	Completed	Elementary/Secondary (0-12) 12 Years	College	(1-4or 5+)	F	Homemaker			Own Home	9
פ	al Hyg	Bec	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	e (First, Middle, M	Maiden Sumame)	
<u>yla</u> ı	should b nd Menti marked umatice	으	William Biela	wski				Anna	Marie M	Maranowcz	
Maryland	2 sh and and is m		19a. Informant's Name/Relations		>					City or Town, State,	
	1 and Health em 27 ther to		Susan Sanders 20a. Method of Disposition	(Daught			Sition (Name of			ena, Maryla 20c. Location - City of	
סר	Pages nent of P ant: if ite		1 ♣ Burial 2 ☐ Cremation		n State	cemetery, crer	natory or other plac	(e)			
altimore,	permit. Page Department of Importent: If any injury or ance.		4 Donation 5 Other (S		Sa		. Of Mar		13/2006	Dundalk,	Maryland
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135		(	23a Part. Enter the disease, or shock, or heart faifure. List	complications that only one cause on	caused the dea each line.	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
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$\sqrt{}$	d d ansit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>S</b> .							
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Box	death certific e attending p d for use as	Ician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1 ☐Live 4 ☐ Preg	utcome of pregn birth 2  Feta nant at time of a	af death 3 □	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
0.	that the de led by the a detached f	Physi	9 🗌 Unknown	9□ Unk	nown						
	The law requires that the death certify ate hes been signed by the attending page 2 should be detached for use as	۵	Part II. Other significant condition	Afthew Le		· 1 /	nderlying cause giv		23e. Did tob	pacco use contribute t es 2 □ No 3 □ P	o the cause of death?
Records,	e law re hes bee e 2 sho	Completed	non busili	Depena	lut	Irobe	4 Med	UT	24a. Was a autops perform	y prior to	utopsy findings available completion of cause of
	n: Th									No 1 ☐ Ye	s 210 No
<b>\rightarrow</b>	sicial	o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospitat	fnpatient 2	ER/Outpatier	± 3□ DOA Oth	00	th (Check only on		
ō	ding Physician: The lav h. After this certificate hes funeral director, pege 2	<b>-</b>	27. Manner of Death	28a. Date	e of Injury	28b. Time of	IL 3 DOA	4 Linuising no		ence 6 Other (Special ow injury occurred	ecity)
<u>o</u>	tending leath. tor; Afte the fun	atio	1 Natural 5 ☐ Pendir 2 ☐ Accident investi	9	nth, Day Year)	fnjury		k? Yes 2 ☐ No			
Division of Vital	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funaral Director: After this certifica completely filled in by the funeral director.	Certification;	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	ined 200. Flat	ce of fnjury - At h ding, etc. (Speci	nome, farm, str	eet, factory, office		28f. Location (St City or Town	reet and Number or F n, State)	Rural Route Number,
_	To the Hospital or At within 24 hours after o To the Funaral Direct completely filled in by		29a. Certifier 1 Certifyir	g Physician: To th	ne best of my kn	owledge, deatl	n occurred at the time	ne, date and place,	and due to the ca	ause(s) and manner a	s stated.
	he Ho in 24 i he Fu pleteli	edical	one)	examiner: On the	basis of examina	ation and/or in	vestigation, in my o	pinion, death occur	red at the time, di	ate and place, and du	e to the cause(s)
	To tro	Σ	29b. Signature and title of certifie				29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
•			Mu	use	u		6	30555	7	Mosery	10,2006
	0		30. Name and address of person Hau N. Sen	who completed cau	use of death (Ite	m 23a) (Type.	Print)	Balk,	eus	21219	
	Sta Regista		31. Date filed (Month, Pay, Year)	32.	Registrar's Sign	ature	will	<del>*</del>			
12.	×-		FED 1	7 7 HUb 2	I Shakkakak	AN PH					

06-00923 B.K.S AARON A. MAYHEW

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryland		artment of t tificate of			iene 006	04129
DH	nysicia	n l	1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	th Day Yea	3. Time of Death
	Medic	_	Aaron Albert Mayh					1	5, 2006	0137 A <sup>M</sup>
E:	xamin	er	4a. Facility Name (If not institution, give st CALVERT MEMORIAL	HOSPITAL			FREDERIC		4c. County of De CALVER	
	neral ector		214-02-1786	7. Age (In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		, Year)	Birthplace (State or Foreign Country) MD
and a	-1		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
Mary	leda	to	MD P.G.	D - 1	4311					11∏ Yes 2 □ No
h the	Total Total	Irec	MD P.G.  10e. Street and Number		tsvill	10f. Zip Code			0g. Citizen of What	Country?
th wit	E E	a D	10602 Worcester Av	/enue		2070	5		U.S.A.	
17215-0036 within 72 hours after death with the Maryland ene.	other treumstic event, the Middel Examiner must be notified at	by Funeral Director	11. Marital Status 1: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	2. Was Decedent Ever in U. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	'	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2X No	an, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White
2 P	ical	ted	15. Decedent's Education (Specify only highest grade		16a. Deced	tent's Usual Occu	pation during most of we	nrkina	16b. Kind of Busines	ss/Industry
21215-0036 ad within 72 hours atl giene.	Iba Mico	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	Mechani	nd)		Building	
Maryland 2.  Nd 2 should be filed v Ith and Mental Hygie 77 emarked other	ic avent,	To Be C	17. Father's Name (First, Middle, Last) Albert Mayhew				18. Mother's Na Joan N	me (First, Middle, losley	Maiden Surname)	
and N	E		19a. Informant's Name/Relationship (Typ	e, Print)	1	-			r, City or Town, State	
and and	or tr		Albert Mayhew - Fa		1		ster Ave		ille, MD	
Baltimore, Denmit. Pages 1 a Department of Hee	to of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re		lace of Dispo emetery, crer	sition (Name of natory or other pla	· 1	Date	20c. Location - City	or Town, State
Fag.	in in		4 Donation 5 Other (Specify)	Ft.		oln Crem			Brentwood	, MD
Department of Processing	any Ir		21. Signature of Funeral Service Licenses	Copple	34	401 Blade	ensburg F		wood, MD	20722
Physi /Med Exan	dical		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,  b.	multiple Due to (or as a consequence)	uence of:	er the mode of dy	ng, such as cardia	ic or respiratory arr	est,	Approximate Interval Between Onset and Death
cate be executed	the burial-transit	dical Examiner	flary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence to (or as a consequence)						
Box 6	by the ellending plantached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	ic. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	death 3	]Ectopic pregnand ] Other (specify) _	ÿ		23d. Date of Month	delivery Day Year
<b>8</b> th	be de	ρ	Part II. Other significant conditions conf	nbuting to death but not res	ulting in the u	ndertying cause g	ven in Part I.			e to the cause of death?  Probably 4 []Unknown
I Rec	cate nes been s , page 2 should	Completed						24a. Was a autop perfor 1 × es	sy prior	
of Vita	rector, p	Be	25. Was case referred to medical examiner?	ospital:	7	- 10:	hoc	eath (Check only or		
D &	al di	7: To	1 X Yes 2 No	28a. Date of Injury	ER/Outpatier 28b. Time o	II 3 DOA	4 🗆 Nursing	7	ence 6 Other (S ow injury occurred	(pecify)
On ding	funer	tlor	1 ☐Natural 5 ☐ Pending 2 € Accident investigation	(Month, Day Year)	Injury	Wo	ork? Yes 2 100	driver	of mot	1 1
Division of or Attending s efter death.	od in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	00.0	reet, factory, office		28f. Location (S City or Tow Powde 4		Rural Route Number, d and Route a
Hospiter 24 hours e	ne runeral Dire	Medical (		ician: To the best of my kno er: On the basis of examina and manner stated.				e, and due to the	ause(s) and manner	as stated.
To the within 2	completely	Me	29b. Signature and title of certifier	C. States.		29c. Licen	se number	;	29d. Date signed (Me	onth. Day, Year)
	- 0		Pot aron	ica-Pollo	L m	3	C.M.E		FEB. 6,	2006
4			30 Name and address of person who con	npleted cause of death (Item			, BALTIM	ORE, MARYI	LAND 21201	
tys T	Sta Registr		31. Dale filed (Month, Day, Year) FEB 1 4 200	32 Registrar's Signa	ature	ade				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBLUARY Year **Physician** 1:30 Agnes Bernice Mitchell 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BCUTIMOTO Baltimore 5. Social Security Jumber HOSPITAL 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Days Hours Months 1 ☐ M 2 🛣 F 216-20-8294 Director 88 Apr 2, 1917 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Iteme 23a or 28a-f ehow the Nedical Examinar must be notified at 1 Yes 2 No Director Maryland Baltimore Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 5713 Edmondson Avenue - Apt A-4 21228 U.S.A death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 Yes 2 XNo þ Specify. Black 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Health Dept. Clerk 12 other Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked othe any njury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Charles H. Clark Geneva Flint 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline Martin Daughter 5203 Hillwell Road Baltimore, Maryland 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 02/13/06 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) **Baltimore National Cemetery** 21. Signature of Funeral Service-Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENCEPHALOPATHY **Physician** ANOXIC /Medical Due to (or as a consequence of): **Examiner** LIVER SHOCK Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner HIGH DEGREE AV BLOCK The law requires that the death certificate be executed TRANSIENT Box 68760, physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 2 Fetal death Month Day Year 4 Pregnant at time of death 5 Other (specify) Ö ď Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy performed? Yes 2 No certificate has 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 XInpatient Certification; To 2 ER/Outpatient 3 DOA this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending To the museum within 24 hours after death.

To the Funeral Director; Aft М 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Zij Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) FEBRUARY, 08, 2006 P17605 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TEOBORA NICULESCU, MD, SAHC, 900 CATON EVE, BALTIMORE, MD, 21229 31. Date filed (Month, Day, Year) 32, Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:30 PM **Physician** 2006 ebruan Dorothy Fleck Mooers /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie Baltimore Washington Medical Center Anne Arundel 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-29-1911 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 200 94 Director 058-16-3331 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Completed by Funeral Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1910 Norman Road 21060 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2√∑No 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 ☒ No Specify: 3 XWidowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) A.A. Co. School System Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Florence Huddleson Frank G. Fleck ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3800 2nd Street; Brooklyn, MD 21225 Mr. Charles Mooers / son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 ⊠Cremation 3 □Removal from State Chesapeake Cremation 2-14-2006 Stevensville, MD 4 Donation 5 Other (Specify) ture of Funeral Service License 22. Name and Address of Facility Singleton Funeral Home, PA 21. Sigi 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Hospital or Attending Physician: The law requires thet the death certificate be executed use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 □Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 NO 1 Inpatient 1 🗌 Yes 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) the funeral 27. Manner of Death 1 Natural 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours efter death uneral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai To the Hosp within 24 ho To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrars State Registrar 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month PHYLLIS MYERS 9:40 pm February 12 7066 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 6502 Home Water Court Glen Burnie 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth July 20, 1931 Birthplace (State or Foreign Country) Funeral Hours Months 1 ☐ M 2 🗷 F 74 214-30-6895 Yrs. Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21060 6502 Home Water Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be John Donnely Matilda Rothenberg ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6502 Home Water Court, Glen Burnie, Maryland 21060 <u>Thomas E. Myers (Husband)</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 02-16-06 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Crownsville VA Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner or Attending Physicien: The law requires that the death certificate be executed sate has been signed by the attending physician and page 2 should be deteched for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 2)X No 1 Tas 3 Probably 4 Unknown ģ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 Yes 2 40 certificate 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Desidence 6 Other (Specify) Hospital: 1 Yes 2 No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospitel or Attending Physi within 24 hours effer death.

To the Funerel Director: After this completely filled in by the funeral dir this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending investigation Injury 1 Tes 2 □ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of contifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print wag MAMINEZ

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** NURRAY 2006 MOLLIE FEBRUARY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BAYVIEW MEDKAL CETTOR BALTIMORE JOHNS HOPKINS
5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex **Funeral** 213-30 -9613 Usual Residence of Decedent November 11: 1930 Director permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If Itam 27 Ie marked other then "naturel", or Itama 23e or 28e-f ehow eny Injury or other treumatic event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21222 U.S.A NVENUL Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married ☐Yes 2 No Baltimore, Maryland 21215-0036 þ f Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homenake 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 homas ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MD 21222 20b. Place of Disposition (Name of cometery, crematory or gither place) Daughter DUN Calk 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cemeke 4 □ Donation 5 □ Other (Specify) 22. Name and Address of acijity

Bradley-HSh to
2134 W/110W 21. Signature of Funeral Service Licensee Home, 1.4 2/222 LON FUNERA 2134 SprING 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) FROM MESA BACTERE MIA **Physician** SEPSIS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine or Attending Physician: The law requires that the death certificate be executed cate hes been signed by the ettending physicien and page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performed certificate 2 No 1☐ Yes Be ( 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 TYes 2 No investigation 2 Accident efter death Director: the 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funeral D 1 Scartifying Physician: To the best of my incivided a death conumed at the time, date and plane, and due to the nausc(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES- 000 30. Name and address of person who completed cause of death ( m 23a) (Type, Print) EASTERN AVENUE 4940 BALTIMORE, MD ROBERT DUHAME 31. Date filed (Month, Day, 32. Registrar's Signature State 4 2006 Registrar

Michael McClain 06-0770 AKG

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#2a,27,22a-f,pents. 682,2/22/16 II

23a,27,28a-f,perME,G852,2/22/06 TT State of Maryland / Department of Health and M	lental Hygiene UU6	04	3
Certificate of Death	Reg. No.		

Physician	
/Medical	
Examiner	

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or items 23s or 28e-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attanding physicien and completely filled in by the funeral director, paga 2 should be detached for use as the buriat-transit Division of Vital Records, P.O. Box 68760,

		1 - State Registrar						Certi	ificate	e of L	Death	1		Reg	No.			
icia	20	1. Decedent's Name	(First, Middl										2. Date o Month		Day	Year	3. Time of Death	
dic					Michae	el Lee	McC1	lain					Janu	ıary	30, 2		7:52 P M	
nin		4a. Facility Name (If 100 block	West	-	ey St	reet				Ba1	Location timo:	re			4c. County	ì		
al		5. Social Security No. 216 86		6. Sex	1 2 F	7. Age ( <i>In yr</i> 37		hday) (rs.	If Under Months	1 Year_ Days	If Under Hours	Min.	8. Date o	Dav. Y	ear)	Col	nplace (State or Foreign untry)	
or		Usual Residence of						113.					Dec.	18,	1968	Mar	ryland	_
		10a. State	10b. County		·	10c. (	City, Town	or Loca	ition								10d. Inside City Limits	_
	ctor	Maryland	Anne	Arur	nde1		Balt	imoı	re								1 ☐ Yes 2 🛣 No	
	Direc	10e. Street and Num							10f. Zip					10g	. Citizen of		untry?	
	rai	927 V	ictory							212					U.S.			
	nue	11. Marital Status		_	Armed Fo		r in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- lf Yes, specify Cuban, Mexican, Puerto Rican, etc.)									ce - Amer ck, White	rican Indian, a, etc.	
	Completed by Funeral Director	1 XNever Married 2 Married 1 Yes, 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:							1 ☐ Yes 2 🙀 No Specify:						Specify: White			
	ete	(Spec	15. Deceder ify only highe	nt's Educa est grade d	tion completed)		16a.	(Give ki	nt's Usua nd of wor	al Occupa nk done d	ation du <i>ring mo</i> s l)	st of work	ing .	16	b. Kind of B	usiness/l	ndustry	
	dwo	Elementary/Second	ndary (0-12)		College (1	-4or 5+)	D		111 F						Cons	truct	tion	
	BeC	17. Father's Name (													iden Sumai			
	၉		Ja	mes M	1cC1ai	.n						Marg	aret	Mari	e Doc	kery		
	1	19a. Informant's Na Michael					19b.	_	Address						ity or Town			
				TII/	DOIL	1206	. Place of				renue	Control Control	Date		c. Location		d 21222	_
		20a. Method of Disp 1 Burial 2	G Cremation		noval from	State _	cemeter	y, crema	tory or o	ther plac								
		4 □Donation  21. Signatuse of Fu				B	ayvie				ss of Facil		/2006	_			Maryland	
once.		21. Signatore of 70			4	-	1					0					e, P.A.	
		23a. Part1. Enter the shock, or hear	he disease, o	cog plica	tions that o	aused the de	ath. Do r									Mary	Approximate	-
		Immediate Cause (	(Final														Interval Between Onset and Death	
in al		disease or condition resulting in death)  Cocaine and Narcotic (heroin) intoxication  Due to (or as a consequence of):														-		
er		Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):																
	/Medical Examiner	if any, leading to im cause. Enter Unde Cause (Disease or that initiated events	injury	ႛ	Due to	(or as a cons	equence	of):										
	al Ex	resulting in death) l	Last		Due to	(or as a cons	equence	of):										8
	adic	d														_		
		IF FEMALE: 23b. Was deceden in the past 12	ic pregnancy						ate of deli	ivery Day Year								
	Completed by Physicia	1 ☐ Yes 2 ☐ 9 ☐ Unknown	□No		4∐Pregr 9☐ Unkn	nant at time o own	death 5 🗌 Other (specify)											
	H.	Part II. Other signif	ficant condit	ions contr	nbuting to d	eath but not i	esulting in	the und	derlying c	ause giv	en in Part	1.	23e.	Did toba	cco use cor	co use contribute to the cause of death?		
	q p												1 🗌 Yes	☐ Yes 2☐No 3☐ Probably 4☐Unknown				
	ojete													Was an	24b.	Were au	itopsy findings available	
,	E													autopsy performe 'es 2 [		death?	completion of cause of	
	BeC	25. Was case refer examiner?	rred to medic	al							26. Plac	e of Dea	th (Check o			- 7		-
	2	1 🔀 Yes 2 🗆		Ho			□ ER/Ou	tpatient			4 🗆 14	lursing H	ome 5	Residen	ce XXOt	her (Spec	cify) at scene	
	on:	27. Manner of Deat 1 ☐ Natural	5 Pend	ing		of Injury th, Day Year		Time of njury		28c. Injun Wor	yat k?	<b>5</b>		ribe how	injury occu	rred		
	cat	2 Accident 3 Suicide	invesi 6 <b>X</b> Could	igation I not be	unk	of faire. A	unk		М		Yes 2	UNO	unk	ion (Ctro	at and Norm	har ar O	and Bouts Name	
•	Medical Certification:	4 🗌 Homicide	4 deten	mined		of finjury - A ing, etc. (Spe at res			et, ractor	у, опісе			Baltim	ore,	State) 100 MD	bloc	ural Route Number, ik W. Barney St	t.
	dicai	29a. Certifier (Check only one)	1 Certify  2 Medica	ing Physic I Examine	er: On the b	e best of my leasis of examiner stated.	(nowledge ination an	e, death id/or inve	occurred estigation	at the tin	ne, date a pinion, de	and place eath occu	, and due to rred at the	the cau	rse(s) and m e and place	anner as and due	stated. to the cause(s)	
	Me	29b. Signature and	title of certifi	er	٠.	,			290	c. Licens	e number	,		29	d. Date sign	ed (Monti	h. Day. Year)	
		1/al	Sal	las	A.					O.C	.M.E.			Ja	nuary	31,	2006	
		30. Name and addr	1000	1)	Ain	se of death (	tem 23a)	(Туре, Р	enn S	Stre	et, E	Balti	more,	Mar	yland	. 21	201	
Sta	ate	31. Date filed (Mon	nth Day, Yea	r)	32. F	Registrar's Si												_
ist	rar	A.	LERI	4 20	06	A Comment	1		246	1								
/ 1/2	2001				e.	100	· - ·	See The lease of	670									_

**ORIGINAL** 

Registrar

ADH TONY A. MULLINS 06-1018

Please Type or Print in Blagk Indelible Ink. Ensure All Copies Are Legible.

L8		1- For Amend item#3 Registrar	State ( ,28b,perME,	of Marylan 3853,3/2/0	id / Depa	irtment of h tificate of	lealth an Death	d Mental H	ygiene Reg. No.	006	04135	
Physic /Med		Decedent's Name (First, Middle		y Allen	Mullins			2. Date of to Month FEBRUAL	Day	, 2006 Year	10:56 AM	
Exam		4a. Fecility Name (If not institution 8740 TAMAR DRIVE	n, give street and nu	umber)		4b. City, Town, o	r Location of C	Death		County of Death	1	
Funera Directo		5. Social Security Number 215-80-7839	6. Sex 1 M 2 ☐ F	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, I	Day, Year)	Col	nplace (State or Foreign untry)	
show		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation		July	1ly 6, 1965 Maryland 10d. Inside City L			
th the Ma or 28a-f s	Director	Maryland 10e. Street and Number	Howard			10f. Zip Code	Columbia	1	10g. Citi	izen of What Co	1 □ Yes 2 No untry?	
death wi	Funerai	8740 Tamar Dr.	12. Was De	cedent Ever in U	.S. 13. \	Was Decedent of H	210 dispanic Origin	45 1? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Amer Black, White		
ours after ral', or Ite	<u>م</u>	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☑ Divorced	ned 1 □Yes	2 No	1	1 □ Yes 2 □ No	Specify:	dono i ilidani, oto.,		Specify:	White	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be inclined any or other traumatic event.	Completed	(Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed College	(1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most o d)		16b. Ki	ind of Business/l Con	ndustry struction	
and yielling 2.12.  2 should be filed within and Mental Hygiene.  Is marked other than sumatic event, the Marken and Mental than and Mental and	å	17. Father's Name (First, Middle,				<u> </u>	18. Mother's	Name (First, Midd				
d 2 should the and Me	ှင်	19a. Informant's Name/Relations	dward Mullin ship (Type, Print)	S				or Rural Route Nun	nber, City o			
Pages 1 and nent of Health int: If Item 27 iry or other tr		Ms. Nichole Ju 20a. Method of Disposition 1 Burial 2 Cremation	3 □Removal from		Place of Dispo	5439 Lawye sition (Name of natory or other pla	342	Date Date	20c. Lo	ocation - City or		
permit. P Departme Importani any injury		4 Donation 5 Other (S		( + Max	Pay XG2	view Crema Name and Addre	ess of Facility	02/16/2006 Home, P.A.	5	Baltin	nore, MD	
		23a. Part : Enter the disease, o shock, or heart failure. Lis	t only one cause on	each line.		er the mode of dyi	Old Colur ng, such as ca	nbia Pike Elli rdiac or respiratory			Approximate Interval Between Onset and Death	
Pnysiciar /Medica Examine	1	disease or condition resulting in death)	-	n Intoxic		mplicating	hyperte	sive heart	disea	96		
uted d	Examiner	Sequentially list conditions, any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Usia k	o (or as a consuc	quenes of:							
icate be executed physician and sthe burial-transit	dical Ex	resulting in death) Last	d	o (or as a consec	quence of):							
The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐Live	utcome of pregn birth 2 Feta gnant at time of c nown	al death 3	Ectopic pregnanc Other (specify)	у		-	23d. Date of delivery Month Day Year		
wrequires that the been signed by should be detailed	۾	Part II. Other significant condit	ions contributing to	death but not res	sulting in the u	nderlying cause gr	ven in Part I.		Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Stunknow			
VII.at DECU	Completed							24a. W au pe	topsy	prior to death?	topsy findings available completion of cause of	
ysiclan: The siscertificate had director, page	To Be C	25. Was case referred to medical examiner?	Hocostal:	Inpatient 2	] ER/Outpatier	nt 3□ DOA Ot	hor	f Death (Check onli	ly one)	6)©Other (Spec	CYTENTE	
Attending Phy ar death.  •ctor: After this by the funeral c	ertification:	27. Manner of Death  1 Natural 5 Pend 2 Accident invest	igation Fnd 2	e of Injury onth, Day Year) /9/2006	28b. Time o Injury1 Fnd 8:5	0:50A Wo	nyat nrk? ]Yes <b>2</b> ¶∑No	28d. Describ				
To the Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certific	3 ☐ Suicide 6 ♣ Could determ	mined 200. Pid	ding, etc. (Speci	nome, farm, sti ify)	reet, factory, office		28f. Location City or Columbia	(Street ar Town, State a, MD	8740 Tame	iral Route Number, <b>prive</b>	
ths Hospi in 24 hou the Funar	Medical	29a. Certifier 1 Certify (Check only one) 2 Medica	ng Physician: To to I Examiner: On the and ma	he best of my knobasis of examination stated.	owledge, deat ation and/or in	vestigation, in my	opinion, death	place, and due to the occurred at the time	he cause(s ie, date and	) and manner as d place, and due	stated. to the cause(s)	
To	2	29b. Signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of certification of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and title of the signature and the sig	er			29c. Licen	se number OME		29d. Da	ARY 10, 2		
61		30. Name and address of person	who completed ca	use of death (Ite			BALTIMORE	E, MARYLAND	, 2120	L_		
S Regis	State strar	31. Date filed (Month, Day, Year		Registrar's Sign	ature	South						

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** Elsie E. Martin 11 45 AM Feb. ruary ,2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Mar. 7, 19 Birthplace (State or Foreign
Country) Funeral 1 M 2 TF 236 44 8031 75 Vrs 1930 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or iteme 23a or 28a-f ahow the Medical Examinar must be notified at Maryland 1 Yes 2 No Anne Arundel Glen Burnie Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7853 Crilley Road Apt. 519 21060 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No ۾ Specify: White 3 Widowed 4 XDivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Holiday Inn permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygier Important: if Item 27 is marked other tt any injury or other traumatic avant, tha once. 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Mills Alice Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Katzenberger/Daughter 1407 Filbert Street Baltimore, Maryland 21226 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 2/11/2006 Baltimore, Maryland 21. Signatur of Pineral Service Licens 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Myocardid 12 hours /Medical Due to (or as a consequence of): Examiner ronary Sequentially first conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons quence of): Examiner ettending physicien and for use as the burial-transit To the Hospitel or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? 2 No 2 🗆 No 1 Yes 1 Yes After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation s after dec. 1/2/Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide within 24 hours a
To the Funeral C
completely filled i Varifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SHAHZAD M.D. AT2438946-F13 February 7, 2006 USMANI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEMORIAL HOSPITAL, MD UBMANI 14. UNION HAHZAD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

FEB 1 4 2006

			For State Registrar	State	of Marylar	•	artment of tificate of		l Mental Hy	giene Reg. No. 0 0	6 04137
	S		Decedent's Name (First, Middle, La	st)					2. Date of De	ath	3. Time of Death
-	Physici /Medic		WILLIA	4 2006	2:33 A M						
	Examin	1.0		i. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death							of Death
		20	NATIONAL NAVAL M		MONT	GOMERY					
*	Funeral Director		5. Social Security Number 6. S 207-28-7115	ex M∑M 2□F	7. Age (In yrs. 69	last birthday) Yrs.	If Under 1 Yea Months Days		in. (Month, Da	th ly, Year) 20, 1936	Birthplace (State or Foreign Country)     Maryland
	pu ,		Usual Residence of Decedent  10a. State 10b. County		100 0	ity, Town or Lo					And train on their
	anyla shov	-	,								10d. Inside City Limits 11 Yes 2 □ No
	Me M	ecto	Maryland Montgome	Ery	Ro	ckville				10-07	
	with 1	급	5 Columbia Court				10f. Zip Code 20850	)		10g. Citizen of V	_
	eath	era	11. Marital Status	12 Was Dec	cedent Ever in U	19 13 1			(Specify Yes or No		States - American Indian,
	ter d	Funeral Director	1 ☐ Never Married 2 ☑ Married	Armed F	orces?		f Yes, specify Cu	ban, Mexican, Pu	erto Rican, etc.)		k, White, etc.
ဗ္ဗ	urs a	ğ	3 Widowed 4 Divorced	If Yes, G Year or I	ive 19	62- 982	1 ☐ Yes 2 💢 No	Specify:		Specity	White
Ö	72 ho	Completed	15. Decedent's E (Specify only highest gr.	ducation		16a. Deced	ient's Usual Occi	ipation a during most of v	working	16b. Kind of Bu	usiness/Industry
2	thin	nple	Elementary/Secondary (0-12)		(1-4or 5+)	life.	DO NOT use retir	ed)	vorking.		
7	ed wi	Con		5+			Physic				e Practice
Maryland 21215-0036	ges 1 and 2 should be tiled within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or Items 23e or 28e-f show or other traumatic event, the Mackical Examinating the multilled at	Be	17. Father's Name (First, Middle, Last						lame (First, Middle		e)
3	ould Men narke	2	William S. McCurle						eth Arnol		
Mai	12 st th and 7 ls n traun		19a. Informant's Name/Relationship (Eleanor H. McCurlo		fo				Rural Route Numb		
<u>ئ</u>	1 an Heall em 2		20a. Method of Disposition	sy / WI			sition (Name of		ckville,		d 20850 City or Town, State
altimore,	ages int of t: If It		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			cemetery, crei	natory or other pi Mary 's	Feb	ruary 9, 2006		ville, Maryland
Ē	artme ortan Injury		21. Signature of Funeral Service Lice			Cem	etery	ress of Facility			
B	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other trae		> Hamagabe	W	MO14	+20 Ro	bert A. P ) West Moi	umphrey Fu ntgomery A	neral Home venue, Rocl	/Rockville kville, Ma	nc. 1 Inc. 1 Inc.
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that one cause on	caused the dea each line.	th. Do not ent	er the mode of dy	ing, such as card	iac or respiratory a	rrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	а	META	ASTATIC	MELANON	ÍΑ			Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):					
	Examine	_	Sequentially list conditions,	b	/24.22.2.2.2.2.2.2						
	led sit	olu	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence or):					
	xecul	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of):					
8760,	cate be executed obysician and the burial-transit	dical E		d							
89		edic		. u.							
Вох	leath certifi attending   I for use as	N.	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		Testania program	ou.		23d. Dat	te of delivery
	requires that the death certifi een signed by the attending hould be detached for use as	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of		Ectopic pregnan Other (specify)			Moi	nth Day Year
P.0	that lhe de ed by the detached	hys	9 Unknown	9LJ UNK	nown						
	es tha igned be de	by	Part II. Dther significant conditions	contributing to	death but not re	sulting in the u	nderlying cause of	iven in Part I.			ribute to the cause of death?
ord	w require been si	ted							- 10	Yes 2 <u>K</u> No	3 Probably 4 Unknown
Vital Records,	aw 2 S	Completed							24a. Was	psv	Were autopsy findings available prior to completion of cause of
H		S							perfi 1 ☐ Yes		death?
Vita	ysician: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:					Death (Check only	one)	
to	S 0	٠ <u>۲</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 X	Inpatient 2	ER/Outpatier 28b. Time o	" 30 DOA		Home 5 Res	how injury occurr	
S	After After	ion	1XNatural 5 ☐ Pending	(Mo	nth, Day Year)	Injury	W.	ork? □Yes 2□No	200. Describe	now injury occurr	60
Division	l or Attending after death Director: After in by the fune	fica	3 ☐ Suicide 6 ☐ Could not I	98 Plac	e of Injury - At h	nome, farm, str	eet, factory, office		28f. Location	Street and Numb	er or Rural Route Number,
á	s after al Dire	Certification:	4  Homicide determined	buil	ding, etc. (Spec	ify)			City or To	wn, State)	
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	dical	29a. Certifier	miner: Un the	ne best of my kn basis of examin nner stated.	nowledge, deat nation and/or in	h occurred at the vestigation, in my	time, date and pla opinion, death of	ace, and due to the courred at the time.	cause(s) and ma date and place,	anner as stated. and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	^			29c. Lice	nse number		29d. Date signer	d (Month, Day, Year)
	, , , , ,		Car000111	)an-	-		990	00650_(N	C)	Februarv	6, 2006
./	11/		30. Name and address of person who	completed car	use of death (Ite	em 23a) (Typ i			NAVAL ME		
1	1.2		COLLEEN A. DOF	RANCE	LCDR N	MC USN			MD 20889		
	Sta Regist	ate	31. Date filed (Month, Day, Year)	E 27	Registrar's Sign	nature	m =				
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DHMH 17 Rev 1/2001

FEB 1 4 2006



Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

LO25			Please 7	Гу <mark>ре</mark> or Prin	t in Bi	ack Ir	ndelibl	e Ink.	Ensure A	I Copies	s Are	Legible.		
lie Moor	ce.	For		State of Ma	ryland	l / Dep	artmer	nt of H	lealth and M	lental Hy	/giene	nnoc	01.10	0
	•	State Registrar				Ce	ertificat	e of l	Death		Reg. No	1000	0413	3
			e (First, Middle, Lasi	)						2. Date of D	eath	V Vaar	3. Time of Dea	ith
Physicia /Medic		LESLIE					MOOI	RE		Febru	ary	9,200 <sup>Year</sup>	4:35 P	М
Examin		4a. Facility Name (	If not institution, give	street and number)			4b. City	, Town, or	Location of Death		4c	. County of Death		
		Saint A	Agnes Hosp	ital			Ва	1tim				n/A		
Funeral		5. Social Security N		x 7. Age ZM 2□F	(In yrs. la		/) If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, D	ay, Year)	Cou	place (State or Fo.	reign
Director	ļ	214 21	4666	Z M Z U F	46	Yrs.				OCT.	14,1	959 TR	INIDAD	
and **	}	Usual Residence o	10b. County		10c. City,	Town or I	Location						10d. Inside City Li	mits
daryl f eho	5	MD.	NONI	7		BAL	TIMO	RE					1 X Yes 2 □	] No
28a-	ect	10e. Street and Nu						p Code			10a. Cit	tizen of What Cou	intry?	
with a or	Funeral Director		lbourne	Road					.229			NIDAD		
ns 23	era	11. Marital Status		12. Was Decedent I	ever in U.S	. 13	. Was Dece	dent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or N		14. Race - Amer	ican Indian,	
riter	필		ried 2√2 Married	Armed Forces? 1 ☐ Yes Y\\ If Yes, Give	io					Rican, etc.)		Black, White		
urs a	þ	3 Widowed	2 2	If Yes, Give 121 Year or Dates:			1X Yes	2∐ No	Specify:			Specify TR T	NIDADIA	N
filed within 72 hours after death with the Maryland Hygiene. other then "natural", or items 23s or 28s-1 show ent. The Medical Examiner must be notified at	Completed	/Sne	15. Decedent's Ed			16a. Dec	edent's Usu	al Occup	ation during most of work	rina	16b. K	(ind of Business/l	ndustry	
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		shock, or hea	art failure. List only o	one cause on each li	10.	. Do not o	intor and the	do or dy ii	ig, suom as carolac	or rospiratory	411000,		Interval Between Onset and Deat	n th
Physician /Medical		disease or condition resulting in death)	on .	a COMPLIC			40	INT	RACRANII	AL N	topi	ACM		
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o H at	1 <u>C</u>	in the past 12		1 Live birth 4 Pregnant at			B⊟Ectopic   B⊟ Other (s		/			Month	Day Year	
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w require been sig should b										1 🗆	Yes 2	.⊠No 3 □ Pro	obabły 4 🗆 Unkr	nown
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The la	E									per 12 Yes	opsy formed? 2 \( \square\)	death?	completion of cause 2 No	3 01
an: 'tifice	0	25. Was case refe	erred to medical						26. Place of Dea	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		754100	20.10	
Physician: The la r this certificete has rai director, page 2	To B	examiner?	No	Hospital: 1   Inpatie	ent 2 vi	R/Outpat	ient 3 🗆 🗅	OA OU	ner: 4 Nursing H	ome 5 Re	sidence	6 ☐Other (Spec	cify)	
<u>a</u> = <u>a</u>		27. Manner of Dea		28a. Date of Inju		28b. Time Injun	of	28c. Injui Wor	y at	28d. Describe	a how inju	iry occurred		
Attending or death. ector: After by the fune	atlo	1 Natural 2 Accident	5 Pending investigation		, ,		м		Yes 2 □No					
r Atte er de recto by tr	Certification:	3 Suicide 4 Homicide	6 Could not be determined	28e. Place of In	ury - At hoi	me, farm,	street, facto	ry, office		28f. Location City or T	(Street a	nd Number or Ru	ral Route Number	,
tei on rs aft et Die	Cer			, , ,	, _ , ,									
To the Hospitei or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical	29a. Certifier (Check only	1 Certifying Ph	ysician: To the best	of my knov	wledge, de	ath occurre	d at the ti	me, date and place	, and due to th	e cause(s	s) and manner as	stated. to the cause(s)	
the h nin 24 the F	fedi	one)		and manner st	ated.									
or or con	Σ	29b. Signature an	d title of certifier				2	c. Licens	se number		29d. Da	ate signed (Montl	n, Day, Year)	

State Registrar

ANA RUBIO, MD
31. Date filed (Month, Day, Year) FEB 1 4 2006

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

An An Rila Rila MD 1111 Penn Street Baltimore, Maryland 21201

OCME

Feb. 10, 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 12:44A M February Helen Agnes Otto 5006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Union Memorial Hospital Baltimore City N/A If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, ) 8-10-1931 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□M 2□ F 74 MaryTand Director 219-28-1795 Usual Residence of Decedent death with the Maryland 10a. State Cockeysville 10d. Inside City Limits permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or items 23a or 28a-f ehow the fujury or other treumatic event, the Modical Examiner must be notified at once. Baltimore 1 ☐ Yes 2 🔀 No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21030 10802 Lakespring Way Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Y Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 Yes 2 No Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Pilarski Edward J. Macko 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2701 Alben Rd. Baltimore, MD 21234 James Otto Jr. / Son Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-17-2006 Baltimore, Maryland Holy Cross Polish Nat. 21. Signature of Euneral Service Licenses 22. Name and Address of Facility 5305 Harford Rd. Leonard J. Ruck, Inc. Funeral Home | Baltimore, MD 21214 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Palmonary Embolus **Physician** hours /Medical Due to (or as a consequence of) Examiner - stage Rena Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed the attending physicien and hed for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal dea 23d Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be deteched 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death2 þ 1 ☐ Yes 2 ☐ No 3 Probably Completed hes been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No this certificete 1 ☐ Yes or Attending Physician: rector, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient Medicai Certification; To 1 ☐ Yes 2 100 2 ER/Outpatient 3 DOA funeral dir 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident efter death 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t 4 Homicide within 24 hours e To the Funeral I To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) T2438946 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Memorial Hospital, Baltimore, MD Ankit MO Union 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

**ORIGINAL** 

			1 - For Stete RegistrarAmend Item	State of Maryl						Reg	ene J. No.	06	04141	
	Physici	an	Decedent's Name (First, Middle, Last	,						Date of Death Month	Day	Year	3. Time of Death	
	/Medi		4a. Facility Name (If not institution, give	E street and number)		4h City		NDLE Location of D		EBRUARY		2006 unty of Death		
	Examir	ier	Saint Joseph	Medical C		Tows			WS 01			Bal	timore	
	Funeral Director		5. Social Security Number 6. S 217-26-3123 1  Usual Residence of Decedent	ex 7. Age (in) 7. Age (in)	vrs. last birthday Yrs.	Months			vin.	Date of Birth (Month, Day, 1) 6/03/19	(ear) 131	9. Birth	place (State or Foreign intry) MD	
	yland now		10a. State 10b. County	10c.	City, Town or L	ocation							10d. Inside City Limits	
	the Marylar 28a-f ehow	by Funeral Director	MD BALT	IMORE	BALTIMO	)RE	Code			100	Citizen	of What Cou	1 ☐ Yes 2 No	
	23a or	i Di	2904 MARNAT ROAD	APT. D			21209					.S.A.		
	ler deatl iteme 2	ner	11. Marital Status	12. Was Decedent Ever i	n U.S. 13.	Was Dece	dent of His	spanic Origin's n, Mexican, Pi	? (Specify	Yes or No-	14. F	Race - Ameri	can Indian,	
900	within 72 hours after death with the Maryland sine. then "naturel", or iteme 23e or 28e-f ehow the Madical Examinat must be codified at	1 by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 M Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes	V	Specify:	derto Mic	ari, 9(c.)	1 _	Black, White	WHITE	
5-0	72 h	etec	15. Decedent's Ed (Specify only highest gra	lucation de completed)	(Giv	edent's Usu e kind of wo	rk done d	uring most of	working	16	6b. Kind o	f Business/Ir	ndustry	
21215-0036	filed within Hygiene. other then	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	TEACI	HER						CATION	N	
Maryland	should be filed within 72 hours nd Mental Hygiene. marked other then "naturel", matic event, the Medical Exa	To Be	17. Father's Name (First, Middle, Last) CHARLES		ORAN			SARAH	1	irst, Middle, Ma			LEHEM	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Menial Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23a or 28a-f ehon eny injury or other traumatic event, it a Madical Examinar must be notified at once.		194 Informant's Name/Relationship (	Type, Print)  WIFE	19b. Mail 290	ing Address 4 MARI	(Street a	D. APT	. D-	oute Number, 6 BALTIM(	ORE,	wn, State, Zij MD 212	209	
Baltimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifi	Removal from State	b. Place of Disp cemetery, cre HEB SHA	ematory or o	other place		Date / 13/2			on - City or T		
Balt	Depertrimports  ony inju		21. Signature of Furteral Service Licer		2	22. Name ar	nd Addres	s of Facility	SOL	LEVINS			, INC. MD 21208	
	Physician /Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. ACUTE MYDCARDIAL INFARCTION  Due to (or as a consequence of):											
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):											
√ ,0	be executed icien and burial-translt	ical Examiner												
8760,	cate b			d										
P.O. Box 6	law requires thet the death certificate be executed as been signed by the attending physicien and 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ f 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	□Ectopic p □ Other (s <sub>f</sub>					23d.	23d. Date of delivery Month Day		
	s thet		Part II. Other significant conditions of	ontributing to death but not	resulting in the	underlying o	ause give	n in Part I.		23e. Did toba	cco use c	contribute to	the cause of death?	
rds	w require been sig should b	ed b	ACUTE RENAL FAILU	RE					_	1 ☐ Yes	2 <b>X</b> N	o 3□Pro	bably 4 □Unknown	
of Vital Records,	hysician: The law requinis certificete has been idrector, page 2 shouk	Completed by							_	24a. Was an autopsy perform	ed?	prior to co death?	opsy findings available ompletion of cause of	
ta	en: T tificet tor, pi	0	25. Was case referred to medical					26. Place of	Death (C	1 ☐ Yes 2X	No No	1 ☐ Yes	2□ No	
f Vi	Physician: this certificral director,	To B	examiner? 1 □ Yes 2X No	Hospital: 1 🔀 Inpatient	2 ER/Outpatie	ent 3 D	Othe			5 ☐ Residen		Other (Speci	ify)	
ion o	Attending Pt r deeth. sctor; After they the funeral	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time Injury	of A	28c. Injury Work 1 🔲 Y	at ? ′es 2 □ No	28d	l. Describe how	injury oc	curred		
Division	el or Atte s after de il Directo od in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, s	treet, factor	y, office		28f.	Location (Stre City or Town,	et and Nu State)	umber or Rur	al Route Number,	
	on the Hospitel or Attending Phy Within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medicai (	29a. Certifier 1  Certifying Ph (Check only 2 Medical Examone)	ysicien: To the best of my niner: On the basis of exar and manner stated.	knowledge, dea nination and/or i	ith occurred nvestigation	at the tim	e, date and p inion, death o	lace, and	I due to the cau at the time, dat	ise(s) and e and plac	manner as a	stated. to the cause(s)	
	To the	Me	29b. Signature and title of certifier			29	c. License	number		296	d. Date siç	gned (Month,	Day, Year)	
/,	A		1 Jean	~~~		_	D 3	80263			05	-41-0	6	
$()^{\lambda}$	/6		30. Name and address of person who	completed cause of death										
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar's S		1601	OSLE	R DR	IVE,	TOWS	JN,	MARYL	AND 21204	

			1 - State Registrar	State of Maryland		rtment of Hotificate of L			iene 2006	04142
	3 1. 1	推	1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month		3. Time of Death
	Physici /Medic		Lois Lenora	Pinkham					ry 11,20	
	Examir	ier	4a. Facility Name (If not institution, give s			4b. City, Town, or		th	4c. County of Dea	
			Future Care Ch  5. Social Security Number 6. Securi		st hirthday)	Reiste		8. Date of Birth	Baltim	
В	Funeral Director		224-32-2350	M X X F 83	Yrs.	Months Days	Hours Min	(Month, Day,	, 1922 N	nthplace (State or Foreign Country)
3.2	ס		Usual Residence of Decedent					500.00	7	
	arylar	_	10a. State 10b. County		Town or Lo					10d. Inside City Limits
	he M	Director	MD Baltim  10e. Street and Number	ore E	Reist	erstown			0.000	1 ☐ Yes ♦ No
	with	ă	-	+10 A0		10f. Zip Code	11126		0g. Citizen of What C	·
	me 23	Funeral	319 Stone Cas	12. Was Decedent Ever in U.S.	13. y	Vas Decedent of His Yes, specify Cubar	21136 spanic Origin? (S	Specify Yes or No-	U.S.A	erican Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or itema 23e or 28e-f show shy injury or other traumatic event, tra Medical Evantrian must be rotified at ODGs.	by Fur	1 ☐ Never Married 2 ☐ Married  XX X Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes XX No If Yes, Give Year or Dates:			Specify:	to Rican, etc.)	Black, Wh	ite, etc. White
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2	led w tygier her th		12 17. Father's Name (First, Middle, Last)		Dr	awing C		me (First, Middle, I	Telep	none
Maryland	ntal F	Be	Golden Ses	lor				Derrick		
2	should nd Me mark matic	ဥ	19a, Informant's Name/Relationship (Ty		19b. Mailin	Address (Street a			City or Town, State,	Zip Code)
	nd 2 stills ar ar trau		Linda Morris /	Daughter						own, MD2113
ē,	s 1 a of Hea item		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of patery or other place			20c. Location - City o	
Ē	Page nent c int: If		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emovaj from State			1	/14/06	Baltimo:	re, MD
Baltimore,	prmit.		21. Signatur of un al Service Lice	19	22	Name and Addres	s of Facility EC	khardt I	Funeral C	hapel P.A.
	207 2 9	1	23a. Part1. Enter the disease, or compli	nn-						Approximate
8760,	cate be executed where the purial-transit in burial-transit in burial-transit	al Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of)	venon	mbolu Thu	nn hosis		Interval Jetween Onset vid Death
Division of Vital Records, P.O. Box 687	t the death certifi by the attending tached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregnan- 1 □ Live birth 2 □ Fetal o 4 □ Pregnant at time of dea 9 □ Unknown	leath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of de Month	elivery Day Year
rds, F	quires tha	Ď	Part II. Other significant conditions cor	tributing to death but not result	ing in the ur	derlying cause give	n in Part I.	23e. Did tot	>	to the cause of death?  Probably 4 Unknown
eco	lew requir es been si 2 should l	Completed		uxobracio				24a. Was a		autopsy findings available ocompletion of cause of
œ —	sicien: The lew certificate hes t lirector, page 2 s	E O		(-1. )				perform	ned2 death?	s 2 No
/ita	cian: ertific	Be (	25. Was case referred to medical examiner?				-	ath (Check only on	е)	
<del>_</del>	hysi this c	ျ	1 □ Yes 2 → No		R/Outpatien		4 wursing		ence 6 Other (Sp	ecify)
S C	ding f	lon	27. Manne of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	8b. Time of Injury	28c. Injury Work	at :? ∕es 2 ⊡No	28d. Describe ho	ow injury occurred	
<u>si</u>	i or Attendatier deati Director: In by the	licat	2 Accident Investigation 3 Suicide 6 Could not be	28e. Place of Injury - At hom	e farm str		- 2 - 140	28f Location (St	reet and Number or F	Rural Route Number
<u>S</u>	after after I Direct	Certification:	4 Homicide determined	building, etc. (Specify)		ot, lactory, office		City or Town		is/diviosito /validos,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	edicai C	29a. Certifier 1 Certifying Physical Check only 2 Medical Examinate	sician: To the best of my knowner: On the basis of examination and manner stated.	ledge, death on and/or inv	occurred at the timestigation, in my op	e, date and plac pinion, death occ	e, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	as stated. ue to the cause(s)
	within To the	Me	29b. Signature and title of contifier			29c. License	1		9d. Date signed (Mor	~ / /
	0			my		1)	2756	7	2/13/	06
1	) Y		30. Name and ad it of pers in who co	mplet - cause of death (Item		183X	Green	~ Tree	2 (131 Rd 2	1208
A STATE OF THE STATE OF	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 4 200	39. Registrar's Signatu	re	tis.			<u> </u>	

			1 - For State Registrar		partment of Health and I ertificate of Death	Mental Hygie	_	14143
100	Dhu-i-i		1. Decedent's Name (First, Middle, Last)			2. Date of Death	Day Year	3. Time of Death
,	Physicia /Medic			ces Phelps		rebruary	10 2006	6,30PM
12	Examin	ier -	4a. Facility Name (If not institution, give :		4b. City, Town, or Location of Death	1	4c. County of Death	
\$ · ·	F		Doctor's Communit  5. Social Security Number 6. Sex	<u> </u>	Lanham  If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Prince Geor	rge 's ace (State or Foreign try)
75	Funeral Director		578-18-8106	7. Age (In yrs. last birthda 86 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) 2/5/1920	Year) Count Washi	ington, DC
1	ow #		10a, State 10b. County	10c. City, Town or	Location		10	Od. Inside City Limits
2	Mary a-feh	tor	MD Prince G	eorge's Hyattsvi	ille			1X☐Yes 2☐No
1	s i and 2 should be lied within 72 hours after death with the maryland if Health and Mental Hygiene. If the marked other than "naturel", or lieme 23a or 28a-f ehow other treumatic event, it a Madical Examination in the notified at	Funeral Director	10e. Street and Number 4808 71st Avenue		10f. Zip Code 20784	10g	g. Citizen of What Count Jnited State	ry? 2.S
1	Iteme	uner	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No	Was Decedent of Hispanic Origin? (S     If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - America Black, White, e	
0000	rei', or	by	3  Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2X No Specify:		Specify: Whi	ite
ב ב	"natu	Completed	15. Decedent's Edu (Specify only highest grade	e completed) (Gi	cedent's Usual Occupation ive kind of work done during most of wor e. DO NOT use retired)	rking	6b. Kind of Business/Ind	ustry
7	giene.	lmo	Elementary/Secondary (0-12)	College (1-4or 5+)	Food Service Worker	P.	.G. Public S	School
yiand	al Hyi	Bec	17. Father's Name (First, Middle, Last)			ne (First, Middle, Ma	aiden Sumame)	
7.0	Ment	ပ	Michael Hassett		Unknown			
Mar	alth and 27 is m		19a. Informant's Name/Relationship (Ty John S. Phelps, J		alling Address <i>(Street and Number or Ru</i> <b>)4</b> 71st Ave Hyatt			Code)
ore,	iges 1 a nt of Hear if Item or othe	2	20a. Method of Disposition  ¶☐ Burial 2 ☐ Cremation 3 ☐ F		sposition (Name of trematory or other place)		Oc. Location - City or Tov	
Baltimor	permit. Pages Department of H Important: If Ite any injury or ot once.		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		ncoln Cemetery 2/1 22. Name and Address of Facility Fo			
מ	Deper Impo		Lehut the		3401 Bladensburg H			
ź			23a. Part1. Enter the disease, or compli	ications that caused the death. Do not ene cause on each line.	enter the mode of dying, such as cardiac	or respiratory arres	st,	Approximate Interval Between
F	hysician		tmmediate Cause (Final disease or condition	A	IRATION PHEU			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	후 , 6주 그	-e	Sequentially fist conditions,	Due to (or as a consequence of).				
	nd	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2.				
,00	eain cernicate be executed attending physicien and for use as the burial-transit		resulting in death) Last	Due to (or as a consequence of):				
780	physicate to the b	dicai		1				
×	cerrifica nding phi use as th	√Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy	_		23d. Date of defiver	~
Ö :	o death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ №6		3 □Ectopic pregnancy 5 □ Other (specify)			Day Year
ר ה	d by the	Phy	9 Unknown  Part II. Other significant conditions con		o underhing course gives in Red I	23e Did toba	acco use contribute to the	e cause of death?
g j	w requires inat the death been signed by the atter should be detached for u	ed by		LENTIA.	e underlying cause given in Fart i.		2 □ No 3 □ Proba	
ပ္	aw as b	ompieted	COR	LONARY BRTERY	DISCASE	24a. Was an autopsy		osy findings available inpletion of cause of
_ '	ete h page	Com				performe	ed? death?	
VIII	Pnysician: In this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:	Other	ath (Check only one)	)	
ō	this ral di	. To	1 Yes 2 No	1 ☐ Inpatient	tient 3 DOA 4 Nursing F	lome 5 Residen	nce 6 Other (Specify,	<u>)                                    </u>
<u>.</u>	Attending Phy ir death. ector: After thi by the funeral o	ation	Vatural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injur				
UNISION	2 0 0	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural State)	Route Number,
<u> </u>	spital or ours after neral Dir filled in		29a. Certifier Certifying Phys	sician: To the best of my knowledge, de	eath occurred at the time, date and place	and due to the cau	use(s) and manner as sta	aled.
:	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examination and/or and manner stated.	r investigation, in my opinion, death occu	irred at the time, dat	te and place, and due to	the cause(s)
. '	within 2	Σ	29b. Signature and title of certifier		29c. License number		d. Date signed (Month, E	
-	/			merry MD	D0058.	240	2/11/06	
6	)		30. Name and address of person who co	ompleted cause of death (Item 23a) (Type MUTIAIH 4203		n ilva	37 C. U. L. L.	NA CATE
in the second	Sta	ate	31. Date filed (Month, Day, Year)		have harder h	10 10 10 10 10 10	-113VILLE,	my 2018
1	Registr	rar	FFR 1 4 200	16 Roman D. A.				

# Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend item#5, per H1, 052,2/1// 00 11 State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month **Physician** 5:36am Marye Elizabeth 2006 Pagnella. Feb. 3 /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Prince Georges Laurel Cherry Lane Nursing Home If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 128-05-<del>06/8</del> Director 90 Sept. 7, 1915 New York Usual Residence of Decedent permit. Pagas 1 and 2 should be filiad within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. Stete 10b County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Prince Georges Directo Maryland Laurel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 10101 Snowden Road 20708 U.S.A. Funeral 12. Was Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Real Estate Broker Real Estate 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Rocco Pagnella Antinita Decarlo 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) Robert Pagnella/Son 5654 Fenwick Dr. Alexandria, VA 22303 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Crerpation 3 ☐Removal from State 4 Donation 5 Other/(Specify) Baltimore Washington Crem. 2/7/2006 Laurel, Maryland 21. \$ignature of Fun Service Licenses \_22. Name and Address of Fecility Fleck Funeral Home 7601 Sandy Spring Road Laurel Maryland 20707 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Ceuse (Final disease or condition resulting in death) /Medical ATTAMOSLUMISB · conomy Examiner Examine ATHONOSCIONOSIS requires that the death cartificate be assecuted attanding physician and for usa as the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Part I. ed by tha a 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown MITHOMENS 0150VBH þ 24b. Were autopsy findings available prior to completion of ceuse of death? within 24 hours aftar death.

To the Funeral Director: Attar this cartificata has baan si complataly filled in by the funaral director, page 2 should 24a. Wes an autopsy performed? Completed 1 Tes 20 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Wes cese referred to medical examiner? å 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 4☐ Nursing Home 5☐ Residence 6 ☐ Other (Specify) 27. Manner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 ☐ Accident 3 Suicide 6 Could not be determined Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier edical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1019220 0 30. Name end address cause of death (Item 23a) (Type, Print) Drive Laurel 9811 Wei 31. Date filed (Month, Day 32 Registrer's Signeture State Registrar

	For State Registrar		State	of Maryla		artment of H rtificate of		nd Mental Hy	ygiene Reg. No.	6 04145
Physician /Medical	Decedent's Nam	ie (First, Middle, l		oseph	Puryea	r		2. Date of D Month	Peb 5, 2006	3. Time of Death 2:30 p
Examiner	4a. Facility Name (		nive street and r Druid Park		•	4b. City, Town, o		Death Saltimore	4c. Count	y of Death <b>N/A</b>
Funeral Director	5. Social Security 1 212-32-4	5943	.Sex 1∭X M 2□F	7. Age (In yr	s. last birthday) 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. (Month, D	irth Pay, Year) <b>3, 1936</b>	Birthplace (State or Foreig Country)     Virginia
/aryland	Usual Residence of 10a. State Maryland	10b. County	N/A	10c. (	City, Town or Lo		ltimore			10d. Inside City Limit  Yes 2 □ N
3a or 28a-fa	10e. Street and Nu					10f. Zip Code	21217		10g. Citizen of	What Country? U.S.A.
should be filed within 72 hours after death with the Maryland of Mental Hygiene.  marked other then "natural", or items 23s or 28s-f show imatic event, the Modical Examiner must be motified at To Be Completed by Funeral Director	3 ☐ Widowed	ried 2∏ Marned 4 <b>K</b> Divorced	Armed	ecedent Ever in Forces? s 21 No Give Dates:		Was Decedent of H If Yes, specify Cub.	lispanic Origi an, Mexican, Specify:	n? (Specify Yes or N Puerto Rican, etc.)	Io- 14. Ra Bla Speci	ice - American Indian, ack, White, etc. Ify: Black
ygiene. ygiene. her then "natur: ht, line Modell in	(Spe Elementary/Sect	15. Decedent's city only highest o	grade complete	d) (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired Secur	during most of	of working		Business/Industry unbar Guard
B e d a B	17. Father's Name		st) r Puryear				18. Mother	s Name (First, Middl	e, Maiden Suma belle Carte	
s 1 and 2 should of Health and Men tem 27 is marke other traumatic	19a. Informant's N	·	(Type, Print)			-		or Rural Route Num ere, Maryland 2		n, State, Zip Code)
Page ent c nt: ff ry or		☐ Cremation 3 5 ☐ Other (Spe	cify)		weste	estion (Name of matory or other place of the Star Ceme 2. Name and Address	etery	Date 02/11/06		- City or Town, State altimore, Md
Departm Departm Imports any inju	1	oud	ESI	EP		Estep Br 1300 Eu	others Futaw Place	uneral Service, Baltimore, Mardiac or respiratory	P. A. d 21217	Approximate
physicien and stee burial-transit and cal Examiner	Sequentially list or if any, leading to in cause. Enter Und Cause (Disease or that initiated event resulting in death)	erlying r injury s	c	o (or as a cons	equence of):	y ar	lery.	Infance		1 dig
ath certifutending or use as	IF FEMALE: 23b, Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	months?	1 🗆 Live	outcome of preg e birth 2 Fe egnant at time of known	etal death 3	Ectopic pregnance Other (specify)	1			ate of delivery fonth Day Year
w requires that the debeen signed by the a should be detached the leted by Physic	Part II. Other sign	ficant conditions	s contributing to	death but not r	esulting in the u	inderlying cause giv	en in Part I.		tobacco use co	ntribute to the cause of death?
								24a. Wa aut per 1 🗆 Yes	opsy formed?	. Were autopsy findings availab prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
hysician his cartiff I director	25. Was case refe examiner? 1 X Yes 2				☐ ER/Outpatie	nt 3 DOA Ott	000	of Death (Check only	rone) sidence 6 □O	ther (Specify)
tal or Attending Physician: is alter death. al Director: After this certification by the funeral director. Certification: To Be C	27. Manner of Dea  12 Natural  2 Accident  3 Suicide	th 5 Pending investigat 6 Could no	ion (Me	te of Injury onth, Day Year)	28b. Time of Injury	Wo	yat rk?  Yes 2 ☐ N	0	how injury occu	
i Diffe	4 Homicide	determine	ed 286. Pla	ilding, etc. (Spe	ecify)	reet, factory, office		City or T	own, State)	nber or Rural Route Number,
To the Hospital within 24 hours a vithin 24 hours a completely filled completely filled Medical Ce	29a. Certifier (Check only one)	2 ☐ Medical Ex	aminer: On the	the best of my k b basis of exami anner stated.	nowledge, deat ination and/or in	h occurred at the til evestigation, in my o	pinion, death	place, and due to the coccurred at the time	e, date and place	nanner as stated.  a, and due to the cause(s)  med (Month, Day, Year)
To To Co o	•		tus					4		
6	30. Name and add	SHMAN	/	27/)	tem 23a) (Type,	Print)	Eny.	Red Ba	et m	( ) -122)
State Registrar IMH 17 Rev 1/2001	31. Date filed (Mo		006	. Registrar's Sig	ORIGII	the state of the s				

			1 - State of Maryland Registrar		artment of Health and Natificate of Death	, ,	2006 04146	
	Physici /Medic		Decedent's Name (First, Middle, Last)     HELEN	PR	ESTON	2. Date of Death Month February	13, 2006 3. Time of Death 5:14 A M	
	Examir	_	4a. Facility Name (If not institution, give street and number) Union Memorial Hospital		4b. City, Town, or Location of Death Baltimore	)	4c. County of Death N/A	
¥.,	Funeral Director		5. Social Security Number 6. Sex $1 \square$ M $2 \cancel{N}$ F 7. Age (In yrs. last $216-12-5997$ Usual Residence of Decedent	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country) 1922 Maryland	
	Maryland f show ied at	tor		Town or Loc	cation 1timore		10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
	death with the Maryland ms 23a or 28a-f show rmust be notified at	I Direct	10e. Street and Number 34 01msted Green		10f. Zip Code 21210	10g	g. Citizen of What Country?  USA	_
920	or Ite	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 MWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 M No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (SI Yes, specify Cuban, Mexican, Puerto I □ Yes 2∑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White	
21215-0036	Page 1	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give I life. D	lent's Usual Occupation kind of work done during most of wor DO NOT use retired) Cretary	king	sb. Kind of Business/Industry Federal Government	
Maryland	s 1 and 2 should be filed wii f Health and Mental Hygiens item 27 Is marked other th other treumatic event, Its	To Be (	17. Father's Name (First, Middle, Last) William B. Longley		Alice		Gallagher	
	and 2 sh aith and 27 is m		19a. Informant's Name/Relationship (Type, Print)  T. Michael Preston (Son)		g Address <i>(Street and Number or R</i> u Goodwood Gardens		City or Town, State, Zip Code)  e, Maryland 21210	
Baltimore,	Page nent o ant: If ury or		1 Burial 2 MCremation 3 Removal from State	ce of Dispos n <i>etery, crem</i>	sition (Name of natory or other place)	Date 20	oc. Location - City or Town, State	
Balt	permit. Pa Departmer Important eny injury once.		21. Signature of Funeral School and Consee Lawson  Lawson  23a. Part1. Enter the disease, or complications that caused the death.	22. Mi	Name and Address of Facility	Funeral 1	Home. Inc.	
	Physician /Medical Examiner	er	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  List only one cause on each line.  Due to (or as a consequence)	nce of):	er the mode of dying, such as cardiac	or respiratory and	t, Approximate Interval Between Onset and Death	
,09289	icate be executed physicien and s the burial-transit	edicai Examiner	causé. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequer	nce of):	Mo	Ver es sumen		_
P.O. Box (	requires that the death certific een signed by the attending f hould be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnanc 1 □ Live birth 2 □ Festal de 4 □ Pregnant at time of deat 9 □ Unknown	eath 3 🗆	DEctopic pregnancy Other (specify)		23d. Date of delivery Month Day Year	
	w requires that been signed b should be deta		Part II. Other significant conditions contributing to death but not resulting LCFT hip fracture, Park				cco use contribute to the cause of death?  2 No 3 Probably 4 Unknown	
tal Rec	The lay	e Completed	25. Was case referred to medical	200			24b. Were autopsy findings available prior to completion of cause of death?  1   Yes 2   No	
of Vi	Physician: rthis certific ral director,	To B	examiner?  1 No es 2 No Hospital: 1 Inpatient 2	3/Outpatien	t 3 DOA Other: 4 Nursing H	ome 5 Residence	ce 6 ☐Other (Specify)	
Division of Vital Records,	or Attending ter death. Irector: After n by the fune	Certification:	27. Manner of Death  1 Natural  2 Raccident  3 Suicide  4 Homicide  28a. Date of Injury  (Month, Day Year)  28a. Date of Injury  (Month, Day Year)  28a. Place of Injury  28a. Place of Injury  (Month, Day Year)  28b. Place of Injury  28c. Place of Injury  27an, 15,2006	ie, farm, stre	Work? 1 ☐ Yes 2 ₹ No			×.
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowle 2 Medical Examiner: On the basis of examination and manner stated.	edge death	n occurred at the time, date and place vestigation, in my opinion, death occu	and due to the cau	se(s) and manner as stated	1
	To the within 2 To the complex	Me	29b. Signature and title of certifier  Stall MD		29c. License number D0061199		d. Date signed (Month, Day, Year)	
0	V		30. Name and address of person who completed cause of death (Item 2)	harles	st. Svite 203.	Tonson	MD 21209	
	Sta Registi		31. Date filed (Month, Day, Year) 32. Registrar's Signatur FEB 1 4 2006	le de la constant de	soli .			

Amend item#1, perf by ,632,2/14/06 TI State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Myrle Livingstone Pardoe, Jr. Year **Physician** PARDUE 1:55 AM myrete 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HUMJED COLUMBIA, MD

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. HUWARD (VTVV) HOSP ITAL Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□ F Director 217 20 6142 Yrs. MARYLAND JULY 13 1926 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or itams 23a or 28a-f show Examiner must be notified at 1 Yes 2 □ No Director mo ELDERS BURG CARROLL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Haalth and Mental Hygiene important: If Itam 27 is marked other than "natural; or Itams 23a any jnjury or other traumatic event, Ita Medical Examination once. 21784 DRIVE 5420 EMERALO Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Nyes 2 No 1944-If Yes, Give Year or Dates: 1951 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White δ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry TATE ARCHITECTURAL Elementary/Secondary (0-12) College (1-4or 5+) Floor DesiGN ENGINEER PRODUCTS 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) MYRLEL. PARDOE, SR. Stephan Lyoia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4421 BARTHOLOW ROOW Stresuille mo 21784 04UGHTER Suzanne UAUIS 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 2/15/2006 Baltimore, mo Park Cen. A ☐ Donation 5 ☐ Other (Specify) LOUDON 22. Name and Address of Facility JN Zun Brun EH & man Co. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 6028 SYKESUILLE ROWN ELDERS BURG MO 21784 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician colitis 1127106 Ischemic /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter or Jernying Cause (Disease or injury that initiated events resulting in death) Last Examiner and I-transit The law requires that the death certificate be executed 2/5/06 Mems 1 - W physician ar Due to (or as a consequence of): Box 68760 Physician/Medical the attanding p use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐Pregnant at time of death 5 ☐ Other (specify) Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown COPD 24b. Were autopsy findings available prior to completion of cause of death? Irsuffictence autopsy performed 1 ☐ Yes 2 ☑ No 2 🗷 No Division of Vital To the Hospital or Attanding Physician: within 24 hours after death,
To the Funaral Diractor: Aftar this certifical 25. Was case referred to medical examiner?
1 Tyes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA naral Diractor: Aftar the filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai Z\_ McJical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Dulan D 0060169 02/11 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11055 Little Patrix ent Pruy Suite 202, Columbia, Ducan, m.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 4 Registrar

			State of Maryland / Departing State  1 - State Registrar  Certification		ental Hygier	2006	04148
	Physici /Medio Examin	al	Decedent's Name (First, Middle, Last)     Charles Aaron Redding  4a. Facility Name (If not institution, give street and number)  4b	b. City, Town, or Location of Death	Feb. 1	Day Year 2 2006 4c. County of Deatl	3. Time of Death 7:00p <sup>M</sup>
	Funeral	·	Golden Crest Assisted Living  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If	Hampstead  FUnder 1 Year   If Under 24 Hrs.   Ionths Days   Hours   Min.	8. Date of Birth (Month, Day, Yea		nplace (State or Foreign
	Director  work standard standa	stor	Usual Residence of Decedent  10a. State  10b. County  Md. Anne Arundel  Jessup		July 7,19	24   Mar	yland 10d. Inside City Limits 1 √ Yes 2 \ No
	72 hours after death with the Maryland "natural", or Items 23s or 28a-f show After Excluding must be notified at	Funeral Director	7810 Clark Rd. D44	10f. Zip Code  20794 s Decedent of Hispanic Origin? (Spe		Citizen of What Co U.S.A.  14. Race - Ame	
5-0036	nours after d urai', or Item	by	1 Never Married 2 Married Tyes, Give 1 1 3 Widowed 4 Divorced Year or Dates:	s Decedent of Hispanic Origin? (Spe as, specify Cuban, Mexican, Puerto I Yes 25 No Specify:		Black, White	te
-61212	within 72 ene. than "na	Completed	(Specify only highest grade completed) (Give kind life. DO I	t's Usual Occupation d of work done during most of workin NOT use retired) plicer	ng	Kind of Business	
Maryland	hould be filed d Mental Hygi marked other matic event, I	To Be C	17. Father's Name (First, Middle, Last)  Aaron Redding  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing A		nce Kirkne	$\mathbf{r}$	iin Codel
	jes 1 and 2 sl of Health and If item 27 is or			lark Rd. D44, Jes	Ssup, Md.	20794 Location - City or	Town, State
Baltimore,	permit. Pages Department of important: If it any injury or o		'4 □Donation 5 □Other (Specify) MILLERS Cht  21. Signature of Funeral Se) ice Licensee 22. Na	ame and Address of Facility	10,2000	Md. 21	
	Physician		23a. Part . Enter the / isease, or complications that caused the death. Do not enter if shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ne mule of Sying, such as cardiac o	នៃព្រះក្នុងខ្លួក ក្រុមក្រុមក្រុ	MO 21	Approximate Interval Between Onset and Death
	/Medical Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Lue to (or as a consequence of):  Due to (or as a consequence of):  Cause (Disease or injury that initiated events  C.	ng Concer Pulmo	0		4mm
,760,	te be executed ysician and ne burial-transit	icai Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.	active Putmir	mary Dr	ln-	2.53
O. Box 68	The law requires that the death certifica tie has been signed by the attending ph tage 2 should be detached for use as th	Physician/Med		topic pregnancy ther (specify)		23d. Date of deli Month	very Day Year
Records, P.	w requires that been signed by should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the under	rlying cause given in Part I.			the cause of death?
		Completed			24a. Was an autopsy performed 1 Yes 2 🗚	prior to death?	topsy findings available completion of cause of
Division of Vital	ing Phys After this uneral di	ation: To Be	2 Accident		n (Check only one) me 5 ☐ Residence 28d. Describe how in		Surviy
DIVIS	he Hospital or Attend in 24 hours after death he Funeral Director: / pletely filled in by the f	il Certification;	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm, street, building, etc. (Specify)  29a. Certifier  1 Certifying Physician: To the best of my knowledge, death oc	,	28f. Location (Street City or Town, St	ate)	
	To the Hospital or within 24 hours after to the Funeral Direction completely filled in It	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or invest and manner stated.  29b. Signature and title of certifier	29c. License number	ed at the time, date	and place, and due	to the cause(s)
8			30. Name and address of person who completed cause of death (Item 23a) (Type, Printed Lands of Park Printed La	D 25443 d, Westminster	2	113/20	04
	Sta Registi	ate rar	31. Date filed (Month, Day, Year) FEB 1 4 2006  32 degistrar's Signature	& Vistanio Te	er, uni	לווה כ	

		State of Maryland / Department of Health and State of Maryland / Department of Health and Certificate of Death		giene	96	04149
		Decedent's Name (First, Middle, Last)	2. Date of Dea	ith		3. Time of Death
Physi		WANDA IRENE SZCZECH	Month 02	09	Year 2006	7:49 P <sup>M</sup>
/Med Exam		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of De			y of Death	7.47 F
Exall	iiiei	Baltimore Washington Medical Center Glen Burnie			Anno	Arunde1
Funera	al .	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 F	Hrs. 8. Date of Birt	h	9. Birthp	lace (State or Foreign
Directo		135-32-2471 1 M 2 F 65 Yrs. Months Days Hours N	May 5.		Cour	WV
		Usual Residence of Decedent	may J	1940		
yland		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
Mac	ğ	MD Anne Arundel Glen Burnio	e			1 ☐ Yes 2X No
1 the	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of	What Cour	ntry?
3a or	<u> </u>	401 Third Avenue, SW 21061			II C	Λ
within 72 hours after deeth with the Maryland jiene. Then "naturel", or Itema 23e or 28e-f ehow the Madical Examiner must be notified at	Funeral		? (Specify Yes or No-	14. Ra	U.S.	
ter iter	퉏	Amed Forces? If Yes, specify Cuban, Mexican, Pu	uerto Rican, etc.)	Bla	ack, White,	etc.
hours after turel', or Ita	ρ	3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Spec	Whit	۵
72 hours af		15. Decedent's Education 16a, Decedent's Usual Decupation		16b. Kind of		
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2 should and Men is marke	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or	eatrice Wi		n State Zin	Code)
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ss 1 and 2 should to 1 Heelth and Ment item 27 is marked rother traumatic		Mr. Kazimier Szczech / husband   401 Third Avenue, SV 20a. Method of Disposition (Name of	W Glen I	Burnie. 20c. Location		
Pages nent of P int: If it		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place)				
Pa tent tent			2/14/2006	Dund	alk, I	Maryland
permit. Pages 1 a Department of Hee Importent: if item	ġ	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	Single	ton Fu	neral	Home, P.A.
2059	a	Mark M. Janeure Mo1357 1 Second Ave S	SW, Glen	Burnie	, Mar	yland 21061
		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as care shock, or heart failure. List only one cause on each line.	diac or respiratory ai	rest,		Approximate Interval Between
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/Medica		Immediate Cause (Final disease or condition resulting in death)  a. Houte My o cardial Inf  Due to (or as a consequence of):  Coverage Ameros cleve	- Ona			
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The law requires that the death certificate be executed to have been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	dicai	d				
ficat phy s th	edic	V				
eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. D	ate of delive	erv
atte for	cial	in the past 12 months?			onth	Day Year
tt the de by the t	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				
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he law requires t he has been signe age 2 should be	Completed	(typer ( ) demz	24a. Was	sy	prior to co	opsy findings available impletion of cause of
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ician: T certificat rector, pa	Be	examiner?	Death (Check only o	ne)		
hysic this co	ဥ	Hospital:	ng Home 5 🗆 Resi	dence 6 □0	ther (Specia	(y)
ding Pt After th funeral		27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 1	28d. Describe	now injury occi	urred	
I or Attending Phy after death. Director: After this i in by the funeral d	atic	2 Accident investigation M 1 Yes 2 No				
Atte	ific	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (3 City or Tox	Street and Nur.	nber or Rura	al Route Number,
Hospital or Attending Physician: As hours after death. Funeral Director: After this certific tely filled in by the funeral director,	Certification:	- Contains, Sto. (Opacity)	5, 6. 701	,)		
ospit hour inert y fille		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p	lace, and due to the	cause(s) and r	manner as s	tated.
To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death cone)	occurred at the time,	date and place	and due t	o the cause(s)
To the within 2 To the comple	×	29b. Signature and rule of certifier 29c. License number		29d. Date sign	ned (Month,	Day, Year)
/		Ithe Markon Trator	4	21	100	6
10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			<u>'</u>	
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4		Odner Chemserly Mrs 277 Veningel	furn K	1 A	-meld	MO DIV
4	State	31. Date filed (Month, Day, Year) 32. Agriculture 31. Date filed (Month, Day, Year)	form K	1 A	rneld	MD 210

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month Year Georgia May Ritter 4:45 AM February 10, 2000 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Uak Crest Village Parkville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) August 23,1911 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2X F 192-32-6578 94 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Parkville 1 ☐ Yes 2X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 8800 Walther Blvd. United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bfack, White, etc. 11. Marital Status ☐Yes 2 XNo Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: white 3 X Widowed 4 □ Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Fred Davis Eudora Shug 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Carozza/daughter 101 Beech Bark Lane Towson, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Northampton Mem Shrine Feb. 14,2006 Easton, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Mitchell-Wiedefeld Funeral Home, Inc. 5000 York Rd. Baltimore, MD 21212 23 P. rt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf Droguestire disease or condition resulting in death) Due to (c) as a consequence of): MINA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetaf death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? anemia 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No autopsy performed? 20 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Physician /Medical Examiner The law requires that the death certificate be executed physicien and s the burial-transit as use as atten for u signed by the a of Vital Records,

o.

Physician

/Medical

**Examiner** 

**Funeral** 

Director

me 23a or 28a-f sho

item 27 is marked other than "naturel", or itame other traumatic event, the Medical Examiner mi

Department of Important: If any injury or once.

Baltimore, Maryland 21215-0036

Directo

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Completed

Be

Exam Completed by Physician/Medical Be Certification: To the funeral

1. Natural

2 Accident 3 Suicide

4 Homicide

29a. Certifier

certificate has birector, page 2 s After

To the Hospitel or Attending after death. filled in by within 24 hours a
To the Funeral C
completely filled

> State Registrar

Medical

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

1 Tes 2 No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

8800 Wilther 31. Date filed (Month, Day, Year) FEB 1 4 2006

5 Pending investigation

6 ☐ Could not be

32 Registrar's Signature a Salar

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

und 2123

			1 _ For State	State of Man		epartment of He Certificate of De			211116	06151
	4 8		Registrar     Decedent's Name (First, Middle)	n, Last)		ertificate of Di		Reg. Date of Death		3. Time of Death
	Physici /Medi		ANGELL	a A RO	USE			Month 2	2006	5:00 A.M
188	Examir Funeral Director	ner	4a. Facility Name (If not institution GLEN BURN  5. Social Security Number  216 18 6167	18 HEALTH	1 & REH n yrs. last birtho 2 Yr.	Months Days	BUR 10 II Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Ye	4c. County of Death  A  9. Birth Co  1923  Mar	nplace (State or Foreign unity) Tyland
	land land		Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town o	r Location				10d. Inside City Limits
	Marylan a-f ehow	tor	Maryland Anne	Arundel	Glen	Burnie				1 ☐ Yes 2X☐ No
	th with the 23a or 28	al Director	10e. Street and Number 729 Seagrove	Road		10f. Zip Code 2106	0	10g.	Citizen of What Co	untry?
980	72 hours after death with the Maryland natural", or Itame 23a or 28a-1 show after Executes for neither at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Eve Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	er in U.S.	<ul><li>13. Was Decedent of Hisp II Yes, specify Cuban,</li><li>1 ☐ Yes 2 ☑ No</li></ul>	panic Origin? (Specify Mexican, Puerto Ric Specify:	y Yes or No- an, etc.)	14. Race - Amer Black, White Specify: Whi	a, etc.
15-0	"natural",	ietec	15. Deceden (Specify only highes	's Education t grade completed)	10	ecedent's Usual Occupation ive kind of work done during ie. DO NOT use retired)	on ring most of working	168	b. Kind of Business/l	ndustry
212	J within jiene. r then "	Completed	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		memaker			Own Hom	ne
Maryland 21215-0036	should be filed within 72 ho Id Menial Hygiene. marked other then "natur matic event, the Madical	To Be C	17. Father's Name (First, Middle, And	rew W. Price	·	18	8. Mother's Name (F Christ	irst, Middle, Mail ine Demb		
<b>Jan</b>	2 m m 2		19a. Informant's Name/Relations Kenneth A. Rou			alling Address (Street and				
	of Health item 27 other tr		20a. Method of Disposition		20b. Place of D	Rapid Wate	r way #30		Burnie, M.	
Baltimore,	Page nent o ant: if ary or		1 😾 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	3 □Removal Irom State pecify)		crematory or other place) ven Mem. Par				, Maryland
Balt	permit. Pag Depertment Importent::i eny injury c		21. Signature of Funeral Service	icemsee	hi	22. Name and Address of 4001 Ritchie				e, P.A. land 21225
***	Physician /Medical Examiner		23a. Part. Enter the disease, or shock, or heart failure. Lest Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a co	OKE					Approximate Interval Between Onset and Death
68760,	ficate be executed physicien and is the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):					
O. Box	The law requires that the death certif vie hes been signed by the attending page 2 should be detached for use ar	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death	3 □Ectopic pregnancy 5 □ Other (specify)			23d. Date of delin Month	very Day Year
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of Vital Records,		Completed	DEMINT	7 A	(			24a. Was an autopsy performed 1  Yes 2	? prior to co	copsy lindings available completion of cause of
Vita	Physician: r this certifice ral director, p	Be	25. Was case referred to medical examiner?	Hospital:		Dther	6. Place of Death (C			
ot	g Physer this seral di	n: To	27. Manner of Death	1 ☐ Inpatient 28a. Date of Injury	2 ER/Outpa	e of 28c. Injury at		5 Residence Describe how in	e 6 Other (Special of the first	ify)
Division	i or Attending i effer death. Director: Affer I in by the funer	Certification:	Variation Natural 5 Pending 2 Accident Investig 3 Suicide 6 Could redetermine	ation of be	- At home, larm	M 1 ☐ Yes	s 2 No	Location (Street City or Town, St	t and Number or Rui	ral Route Number,
Ü	Hospital	edicai Ce	29a. Certifier Check only 2 Medical I	g Physician: To the best of m  Examiner: On the basis of exa and manner stated	amination and/o	eath occurred at the time, r investigation, in my opini	date and place, and ion, death occurred a	due to the cause	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	₩	29b. Signature and title of certifier	1-1	1	29c. License nu			Date signed (Month	
			1 Kich	and 2,	1/M	D DOZ	2519	Z	-9-20	006
			30. Name and address of person of RIC HARL  31. Date filed (Month, Day, Year)	the completed eause of death	(Item 23a) (Ty	De, Print)	GTOAL	A 12 1	BALTIA	10175 >100
	Sta			44	Signature	20 a	ejoro k	10-16	Jew III	CILCICO!
	Registr	ar	FEB 1 4 200	6 Breus A	ASSA					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OBINSON 815 2006 4a. Facility Name (If not institution, give street and number) BALTIMORE REHABILITATION EXTEN 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE BALTII DCARE-8. Date of Birth (Month, Day, Year) Aucz 18, 1947 6. Sex 1 2 M 2 □ F If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8 217-46-2785 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits NIA 1 Yes 2 □ No Baitimore

**Funeral** Director with the Maryland a 23a or 28a-f ahow wat be notified at permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Itam 27 Is marked other than "natural; or Itema 23a any injury or other traumatic avent, the Medical Examinant and and anota. Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

10a. State

MD

ctor

Physician /Medical Examiner

within 24 hours after death

To the Funeral Director:
completely filled in by the

ire	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Co	untry?
aiD	2309 Druid	Hill Ave 2	F/ 21	217		USIV	4
nue	A	Vas Decedent Ever in U.S. Armed Forces?	13. Was Decedent of H If Yes, specify Cub.	lispanic Origin? (Specify an, Mexican, Puerto Rica	Yes or No- n, etc.)	14. Race - Ame Black, White	ncan Indian, e, etc.
Completed by Funeral Dire	- CT. 11	Yes 2 ☐ No Yes, Give Year or Dates:	1 ☐ Yes 2 X No	Specify:		Specify: B	lack
lete	15. Decedent's Educatio (Specify only highest grade con		Decedent's Usual Occup	during most of working	16b.	Kind of Business/	Industry
Comp	Elementary/Secondary (0-12)	College (1-4or 5+)	Carper		(	ionstr	uction
To Be	17. Father's Name (First, Middle, Last) George Henry	Robinsons	Sr.	18. Mother's Name (Fin			Blacken
-	19a. Informant's Name/Relationship (Type, F	Print) 19b	o. Mailing Address (Street	and Number or Rural Ro	ute Number, City	or Town, State, Z	(ip Code)
	Jeanne E. Rubin	ison 12	1699 Blan	chard Rd.	Greenw	rook Dela	wave 1990
	20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Remo 4 □ Donation 5 □ Other (Specify)	val from State   cemete	of Disposition (Name of ary, crematory or other plant			Location - City or	Town, State Acid Marylan
	21. Signature of Funeral Service Licensee		4				
	> Oconered a	Japan	10 E.	ss of Eacility Next North	i are,	Bulle.	md. 21201
	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cather than the cause (Final states).	luse on each line.	not enter the mode of dyir	ng, such as cardiac or res	spiratory arrest,		Approximate Interval Between
	disease or condition resulting in death)	UNG CAR	RCINOMA	NON S	MALC	CELL	
xaminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	OI):	tsis To	BRI	411	
dical E	d	200.00 (0.000 200.000 200.000					
Completed by Physician/Medical Examiner	in the past 12 months?	f yes, outcome of pregnancy □ Live birth 2 □ Fetal death □ Pregnanl at time of death □ Unknown	3 □Ectopic pregnancy 5 □ Other (specify) _	,		23d. Date of deli Month	overy Day Year
y P	Part II. Other significant conditions contribu				23e. Did tobacco	use contribute to	the cause of death?
ted b	CHRONIC OBS		LUNG 1	DISEASE	1 ☐ Yes	2□No 3 <b>⊠</b> Pro	obably 4 Unknown
pie	ALCOHOL ABI	ISE			24a. Was an autopsy	24b. Were au	lopsy findings available completion of cause of
Con					performed? 1 ☐ Yes 2 🗷 N	death?	2 No
Be	25. Was case referred to medical examiner?	10.75		26. Place of Death   Ch	neck only one	-	
2	1 ☐ Yes 2 No Hospi	ital: 1 ☐ Inpatient 2 ☐ ER/Ou		er: 4 Nursing Home	5 Residence	6 □Other (Spec	cify)
atlon:	27. Manner of Death  1 KNatural 5 Pending 2 Accident investigation	(Month Clay Vone)	Time of Injury 28c. Injury World 1	y at 28d. k? Yes 2 □ No	Describe how inj	ury occurred	
Sertific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	Be. Place of Injury - At home, la building, etc. (Specify)	arm, street, lactory, office	281.	Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
Medical Certificatio	Check only 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination an and manner stated.	e death occurred at the thind/or investigation, in my o	ne, data and place, and pinion, death occurred a	due to the dause( t the time, date as	s) and manner as nd place, and due	to the cause(s)
ž	29b. Signature and title of certifier	ashmi,	MD D2			ate signed (Monti	
	30. Name and address of person who compte SHERA HASHM	eted cause of death (Item 23a)  1 MD 3900 (	(Type, Print) 2CH RAVEN	BEVO BI	ALTIMO .	RE 21	218

State Registrar

31. Date filed (Month, Day, Year)

4 2836

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 8, 2006 **Physician** 1:57 P M Edward Louis Robinson, Sr. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Wilson Health Care Montgomery Gaithersburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Dec. 11, 1921 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 84 Yrs. Director 485-07-9154 Illinois Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural; or itama 23a or 28a-f show traumatic evant, the Medical Exama as most be notified at 1 ☐ Yes 2X No Director Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13313 Darnestown Road 20878 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give WWII Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Foreign Service Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental is marked o Howard E. Robinson Mildred Cady Walls 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 13313 Darnestown Road, Gaithersburg, MD 20878 Mary Blair Robinson/Wife 20b. Place of Disposition (Name of Monte of Monte of Crematory or other place)

Crematorium, Inc. 12, 2006 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: if it any injury or o 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Bethesda, Maryland \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name an Address of FacilityRobert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue 21. Signature of Furreral Service Licenses M01386 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) patu metastasas **Physician** In grantle /Medical Due to ras a consequence of): Examiner Lelanos Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed use as the burial-transit been signed by the attending physician and should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by puterison Alceraline 1 Yes 2 No 3 Probably 4 Unknown inter: 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No page 2 this certificate 1 Yes 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Datural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Diractor: filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier HRAbertburk tura 201 RUSELLAVERUE 30. Name and address of person who completed cause of death (Item 23) (Type, Print) L. ROBERTBIRSCHBARLY WAS 31. Date filed (Month, Day, Year) FEB 1 4 2005 Registrar's Signature Registrar

			For State Registrer	State of N	aryland / D	epartment Certificate				giene	6	04154
	Physici		1. Decedent's Name (First, Middle, L.	•	n Williar	n Raborg			2. Date of De Month Febru	ath Day	Year 2006	3. Time of Death 4:55 A M
	/Medic Examin		4a. Facility Name (If not institution, gi	ve street and numbe		4b. City, T	own, or L	ocation of De		4c. County	of Death	re Co.
	Funeral Director		5. Social Security Number 6. 219-10-0476  Usual Residence of Decedent	Sex 7. A 1 ☑ M 2 ☐ F	Age (In yrs. last birth	rs. If Under 1	Year Days	If Under 24 H Hours M		y, Year)	Cour	lace (State or Foreign stry) Land
	a Maryland a-f show	ctor	10a. State 10b. County	timore	10c. City, Town	or Location		-	Edgemere		1	0d. Inside City Limits 1 ☐ Yes ※※No
	h with tha 3a or 28 st be no	al Director	10e. Street and Number 14 Shore Road			10f. Zip C	Code	21219		10g. Citizen of		•
920	ges 1 and 2 should be illed within 72 hours after deeth with the Maryland it of Health and Mental Hygiene.  If Itlam 27 is marked other than "natural", or Items 23s or 28s-f show or other traumatic event, Ite Medical Exertical retaint to notified at	by Funeral	11. Marital Status  1 □ Never Married 2∑ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 1 Yes 2 If Yes, Give Year or Dates	5? ]Νο <i>Μ</i> Μ <i>λΤ</i> ΤΤ	13. Was Decede If Yes, specifi		panic Origin? , Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	- 14. Rad Bla Specif	ce - Americ ck, White,	
21215-0036	i within 72 ho iene. r than "natur it e Medical	Completed	15. Decedent's 8 (Specify only highest gi Elementary/Secondary (0-12) 8 Years	Education rade completed) College (1-4o	r 5+)	Decedent's Usual Give kind of work life. DO NOT use	done du retired)	ring most of v		16b. Kind of B		il Co.
nd	2 should be filed withir and Mental Hygiene. Is markad othar than aumatic evant, Ite M.	To Be C	17. Father's Name (First, Middle, Las Joseph Raborg	t)				18. Mother's N	lame (First, Middle, ginia Bak		ne)	
, Mary	and 2 should alth and Men 27 Is marka ar traumatic		19a. Informant's Name/Relationship Mrs. Minnie M. I			Mailing Address (	_	_	Rural Route Number nere, Mar		State, Zip 21219	
Baltimore,	permit. Pages 1 and 2 of Depertment of Health are Important: If Itam 27 is any injury or other traucone.		20a. Method of Disposition 1    Burial 2 □ Cremation 3 □ 1 □ Donation 5 □ Other (Spec		e cemetery	Disposition (Name , crematory or oth and Mem.	er place)		Date 2/10/200	20c. Location -		wn,State e, Marylan
Balt	permit. Depertri Imports any Inju		21. Signature of Funeral Service Lice	na		7922	Vise	Ave.	al Home o	Maryla		nc. 1222
1	Physician /Medical		23a art1. Enter the disease of construction of the construction of	_a	ed the death. Do not line.  Station Consequence of	ot enter the mode	of dying,	hyth	iac or respiratory as	rrest,	6	Approximate Interval Between Onset and Death 3-4-093
	cate be executed  physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	s a consequence of	): (	91	dia	nyo po	thy	(	m-Kreion
P.O. Box 6	The law requires that the death certific sie has been signed by the atlending p age 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		e of pregnancy 2	3 ⊟Ectopic pred					te of delive	ry Day Year
rds, P	w requires that been signed b should be deta	b	Part II. Other significant conditions	contributing to death	Anom	. 7	) ve	in Part I. Michle		obacco use cont Yes 2 □ No	ribute to th 3 □ Prob	e cause of death? ably 4 Hunknown
l Reco		Completed	_ Dementio	· Ch	anic N	enel	in	suffice		an 24b.	Were auto prior to cor death? 1   Yes	psy findings available inpletion of cause of
	ing Phyalcian:  After this certific tuneral director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 Vol  27. Manney of Death  1 Natural 5 Pending 2 Accident investigatic	Hospital: 1 Inpa 28a. Date of In (Month, D			Other:	41 Nursing	y Home 5 ☐ Resident 28d. Describe to			r)
Divisi	si or Attandi after death. I Director: A d in by the fu	Certification;	3 Suicide 6 Could not a determined	28e. Place of !	njury - At home, farr etc. <i>(Specify)</i>	n, street, factory,	office		28f. Location (S City or Tov	Street and Numb vn, State)	er or Rura	l Route Number,
	To the Hospital or Attanding within 24 hours after death. To tha Funeral Director: Afte completely filled in by the fune	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysicien: To the bes miner: On the basis and manner:	of examination and	death occurred at for investigation, in	the time	, date and pla nion, death oc	ce, and due to the curred at the time,	cause(s) and ma date and place.	anner as st and due to	ated. the cause(s)
)	To the To the Comp	M	29b. Signature and title of certifier	M-D		29c.	License I	387.	54	29d. Date signe	d (Month.	Day, Year) 2006
(	3+1		30. Name and address of person who	completed cause of	death (Item 23a) (T	PASTE	RN	BLI	54 10. M	D . 2	122	1.
	Sta Registi		31. Date filed (Month, Day, Year)	2006 32. Regis	trar's Signature	Societis	3.					

		1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H tificate of			giene () () Reg. No.	6 0	4155
		1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year 3	3. Time of Death
Physic /Med		Leroy Rector	Jr.				Feb.	10 200	0 6	5:45pм
Exami		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Deal	h	4c. County	of Death	
		Ivy Hall Nursi	ng Cent	er	Middl	e Rive	c	Balt	imore	
Funeral		5. Social Security Number 6. Sex	,	ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	8. Date of Birt	<sup>th</sup> у. <i>Үөаг)</i> 7,1920	9. Birthplace	e (State or Foreign
Director		220-01-0007	M 2□F	85 Yrs.			Oct.2	7,1920		PA
pu .		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	artion		·		10d	Inside City Limits
anyla sho	7	MD Baltimo	re		te MArs	:h			100.	1 Yes 2 No
Ne M	Funeral Director									
with the	Dir	10e. Street and Number			10f. Zip Code			10g. Citizen of W	hat Country	?
ath v	rai	10326 Vincent		=	211			USA		1-8-
er de Item	une		12. Was Decedent Armed Forces:	?	Was Decedent of I f Yes, specify Cub	lispanic Origin? (S an, Mexican, Puer	specify Yes or No- to Rican, etc.)		- American k, White, etc.	
36 saft	by F	1 Never Married	1 Yes 2 If Yes, Give Year or Dates:	No	Yes 2√2 No	Specify:		Specify	Nhite	
5-0036 72 hours after death with the Maryland naturel', or items 23e or 28e-1 show after Examinat must be notified at	ed k	15. Decedent's Edu		16a Decer	ient's Usual Occup	nation		16b. Kind of Bu	siness/Indus	try
21215-0036 Id within 72 hours aff giene er then "naturel", or the Medical Exam	Completed	(Specify only highest grade	e completed)	(Give	kind of work done	during most of wo	rking	TOD. Talla of Da	31110332111043	u y
with one that	Juc	Elementary/Secondary (0-12)	College (1-4or	5+) Se	lf-empl	oved		Harewa	ire St	tore
Hygined Hygined Stherman	Ü	8th 17. Father's Name (First, Middle, Last)		1	- 9		me (First, Middle,	Maiden Sumame	e)	
Maryland Id 2 should be file Ith and Mental Hy 27 Is marked oth Treumetic event	To Be	Leroy Rector S	r.			Geneva	Davis			
shoul ad Ma mark	Ĕ	19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailir	g Address (Street	and Number or R	urai Route Numbe	er, City or Town,	State, Zip Co	ide)
Mar Ith ar 27 Is	1	Elizabeth Rect			26 Vinc					
Hear Hear		20a. Method of Disposition	-,	20b. Place of Dispo			Date	20c. Location -		, State
ages int of t: If it		1 Donation 5 Other (Specify)	lemoval from State	OakLawn			23/06	Baltim	oro	MD
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 271s marked other than "naturel", or items 23e or 28e-f show any injury or other treumetic event, the Marstral Exam national the notified at any onlines.	41	21. Signature of Funeral Service License	99	1		- , .				
De per Per Per Per Per Per Per Per Per Per P		K TILL	1/1	1/1/	200 14-	, CC	nnelly	Funeral	Home	ofEssex
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		23a. Part 1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final	cause on each I	ine.				4		terval Between nset and Death
Pnysician /Medical	_	disease or condition resulting in death)	COK	MAKY	HK/G	RY D	ISEA-	32		
Examiner		1	Due to (or as	a consequent of):	106	LL170	00			
	e e	Sequentially list conditions, if any, leading to immediate	ue o (or as	a consequence of):	ME		13		_	
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the d	ysic	1 Yes 2 No	9□ Unknown	at time of death 52	JOHNER (Specify)					
		Part II. Other significant conditions con	ntributing to death t	out not resulting in the u	nderlying cause gr	ven in Part I.	23e. Did to	obacco use contr	ibute to the o	cause of death?
<b>လ</b> 8 <u>6</u> 8	d by		-				101	Yes 2□No	3 Probabl	y 4 Dunknown
Record he law requir e has been s	Completed						040 1450	045 4		. Gardinaa assasiahta
Heconomical language 2 sl	mpi						24a. Was autop	osv p	rior to compl eath?	findings available letion of cause of
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of Vital F Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		Ott		ath (Check only o	ne)		
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	lo	27. Mann of Death 1 atural 5 Pending	28a. Date of Inju (Month, Da	ury 28b. Time of Injury	Wo		200. Describe i	now injury occurre	90	
Vision Attending or death. ector: Afte	Certification:	2 Accident investigation 3 Suicide 6 Could not be	00. 81			Yes 2 □ No	206 Leasting (	Change and his make	or and Oram I O	auto Mumbos
	T.	4 Homicide determined	28e. Place of In building, e	ijury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		City or Tov	Street and Numbe vn, State)	er or Hurai H	oute Number,
Divisit To the Hospitel or Attend within 24 hours after death To the Funeral Director: completely filled in by the		CO. Continu								
Hosp 14 ho Fune tely f	icai	(Check only 2 Medical Exami	ner: On the basis of	of my knowledge, death of examination and/or in	n occurred at the trivestigation, in my o	me, date and plac ppinion, death occ	e, and due to the urred at the time,	cause(s) and mai date and place, a	nner as state and due to the	ed. e cause(s)
thin 2 the mple	Medic	29b. Signature and title of certifier	and manner st	tat <del>9</del> 0.	29c. Licens	se number		29d. Date signed	(Month Day	v. Year)
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		*XWINKEY	u su	ug MI	<i>y</i> .	-118	0	2/12	100	
		30. Name and address of person who co	ompleted cause of	death (Item 23a) (Type.	Print)	VI.	De	2/12 falk 1	12 2	222
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C	tate	31. Date filed (Month, Day, Year)	· 32. Regist	rar's Signature	rue	1 lace	Jano	ruce 19	(1) 24.	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a.perFH.(852.2/14/06 TT State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) FEBRUARY 10 **Physician** CINDY ROSENBACH 2006 8:30P /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner NORTHWEST HOSPITAL CENTER RANDALLSTOWN BALTIMORE If Under 1 Year | ff Under 24 Hrs.
Months | Days | Hours | Min. 8. Date of Birth 09/13/1953 Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕶 F 52 214-64-1569 MD Yrs Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. fnside City Limits 10a. State 28a-f show other treumatic event, the Madical Examiner must be published at 1 Yes 2 No BALTIMORE BALTIMORE Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō U.S.A. 12136 VELVET HILL DRIVE 21117 or iteme 23a Funeral death 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No WHITE À Specify. 3 ☐ Widowed 4 ☐ Divorced "naturei", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Efementary/Secondary (0-12) College (1-4or 5+) nit. Pages 1 and 2 should be filed within entment of Health and Mental Hygiene. ortant: if item 27 is marked other ther Injury or other treumstic event, the M. MANAGER ART 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be SHAPIRO SIEGEL HARRY LILLIAN 19a. Informant's Name/Relationship (Type, Print) Rosenbach LOUIS ROSEENBACH / HU 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12136 VELVET HILL DRIVE HUSBAND OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment o important: if eny injury or once. BETH EL MEMORIAL PARK 02/13/2006 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arteniosclenotic ( **Physician** LOYRONS /Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): the attending physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 KNo Month Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. After this certificate has been signed by the a tuneral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ♣ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 N No 1 ☐ Yes 2 No 1☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1XYes 2 No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No efter death. 2 Accident the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours e To the Funerei D Hospitai 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura 01866 February 11, 2006

State Registrar 31. Date files (Month, Day, Year) 1 4 2006

Philip Militello, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Baltimore, Maryland 21215-0036

Box 68760,

CT. Lutherville, MD

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 17:55 M LYNNE FEB SMITH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BATMORE UNIVERSITY OF MANIAND MANICA CONTOC If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 069-46-3402 1 M 2 KF Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or Itema 23a or 28a-f show the Medical Examinar must be notified at 1Д(Yes 2□No Be Completed by Funeral Director DARLINGTON 10e. Street and Number 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1□ Yes 2 No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ZN5URANC permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: if Item 27 is marked other tt
any njury or other traumatic event, Itaa 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) UNKNOW N MARGANELI MARIAN 19a. Informant's Name/Relati Inship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4539 CONOWINGO Stephen Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 A Cremation 3 ☐ Removal from State une Baltemore 4 ☐ Donation 5 ☐ Other (Specify) / Cem Green nomit 21. Signature of Funeral eryce License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death PANCREATIC CANCER **Physician** /Medical Due to (or as a consequence of): Examiner 7 MONTHS Sequentially list conditions, If any lading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of attending physicien and for use as the buriat-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): O. Box 68760, Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown ate has been signed by the atte page 2 should be detached for Month Day Year 4 Pregnant al time of death 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? res 20 No 1 Yes 2 No 1 Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one) 1 ☐ Yes 2 No Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Medical Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 ☐ Could not be 3 🗌 Suicide within 24 hours efter de To the Funeral Diracto completely filled in by ti 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier 29b. Signature and this of certifier 29d. Date signed (Month, Day, Year) AU4176435516701 FEB 07 2006 MD 30. Name and address of person who co to sted cause of death (Item 23a) (Type, Print) GRAHAM SNYDER BARMONE, MO ZIZOI ZZ S GREENE ST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

		•	For State Registrar	State of M	aryland / Depa	artment of H			giene Reg. No. ()	06	041	58
	Physicia	w an	1. Decedent's Name (First, Middle, La	st)				2. Date of De Month	ath Day	Yeer	3. Time of	
	/Medic	al	Joseph Borden Smi					Februa		2006	8:30	P M
ě.	Examin	er	4a. Facility Name (If not institution, given 3910 Ausherman Ro	•		4b. City, Town, or Knoxvill		tn		nty of Death derick		
	Funeral	`	Social Security Number 6. S	ex 7. Ag	e (In yrs. last birthday)	If Under 1 Year	If Under 24 Hr	s. 8. Date of Bir	4h	O Dieb	place (State ontry)	or Foreign
×.	Director		255-05-3320	MM 2□F	93 Yrs.	Months Days	Hours Min	(Month, Da	28, 191	2 Tex	kas	
	land ow		Usuel Residence of Decedent  10a. State 10b. County	<u>.</u>	10c. City, Town or Lo	ocation					10d. Inside C	ity Limits
	Mary	tor	Maryland Freder	ick	Knoxvill	e					1 🗌 Yes	2 <b>™</b> No
	or 28	Funeral Director	10e. Street and Number	_		10f. Zip Code			10g. Citizen			
	s 23a	rai	3910 Ausherman Ro	<del></del>	Funcia II 6		758	Canada Van an Na		d Stat		
	r Rem	Fune	11. Marital Status 1 ☐ Never Married 2XX Married	12. Was Decedent Armed Forces? 1 XXYes 2	No 1934-	Was Decedent of H f Yes, specify Cuba		rto Rican, etc.)	14. F	Race - Americ Black, White,		
9	rel', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1972	1 ☐ Yes 2 ☑ No	Specify:		Spe	city: Whi	ite	
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<u>Jar</u>	Menta Menta arked	To E	Joseph Borden Smi	th, Sr.			Margar	et Grier				
Jan	l 2 sho		19a. Informant's Name/Relationship (Marian V. A. Smit	**		ng Address <i>(Street a</i> Ausherman			-		Code)	
	1 and Health em 27		20a. Method of Disposition	II / WITE	20b. Place of Dispo	sition (Name of	1	Date		on - City or To	own, State	
altimore,	Pages ment of I ant: If Its ury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		Resthaver	natory or other place Cremator	ICU	2006	Fuele	anla 3	fam., 1 a.	I
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	To the Hospital or within 24 hours afte To the Funeral Directional Completely filled in	Medical	29a. Certifier (Check only one) 1 ☑ Certifying Ph 2 ☐ Medical Exam	nysician: To the best niner: On the basis of and manner st	of my knowledge, deat f examination and/or in ated.	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and date and place	manner as s e, and due t	stated. o the cause(	s)
	To the I within 2. To the I complet	Σ	29b. Signature and title of certifier	RI		29c. License			29d. Date sig			
•	ckl		* Krong	x- Man	man	D 139	71		Februar	y 13,	2006	
	10x1		30. Name and address of person who Robert L. Kaufman		meath (Item 23a) (Type, 300 West 9t		Freder	ick. MD	21701			
*	Sta	te	31. Date filed (Month, Day, Year)	32. Redistr	ar's Signature	200		,				
	Registr	ar	FEB 1 4	2006	me At A	faile						

	•	1 - State of Maryland / D	ера		ealth a	and M	lental Hy		006	0 1	59
		Decedent's Name (First, Middle, Last)					2. Date of De. Month		Vana	3. Time of	Death
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Examilie	<b>#</b> 1	Bayview Care Center		•	timo				n/a		
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birts	hday)	If Under 1 Year	If Under	24 Hrs.	8. Date of Birt	th Vanel	9. Birthp	olace (State of	r Foreign
Director		220-44-7305 1□M 2ДF 100 100 100 100 100 100 100 100 100 10	Yrs.	Months Days	Hours	Min.	1997 27	05"	Mar	791and	
nylan how		10a. State 10b. County 10c. City, Town	or Lo	cation					1	I0d. Inside Cit	•
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Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Importent: If Item 27 is marked other than "neturel", or Items 23a or 28e-f show any injury or other treumatic event. The Medical Examinat must be notified at purg.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		Vas Decedent of His fYes, specify Cubar I□Yes 2⊠No	spanic On n, Mexicar Specify:	gin? (Spe ), Puerto	Rican, etc.)		Black, White,		
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21215-0036 ad within 72 hours ati giene er than "neturei", or tha Medical Exam.	ple	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give l	kind of work done d DO NOT use retired)	uring mos	t of worki	ng			,	
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Physician		23a. Part1. Enter the di-ease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition								Approximate Interval Betv Onset and D	een
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Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, Iar building, etc. (Specify)	m, stre	eet, factory, office			28f. Location (5 City or Tow		Number or Rura	I Route Numb	oer,
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To th withir To th comp	Me	29b. Signature and title of certifier		29c. License	number			29d. Date :	signed (Month,	Day, Year)	
		* Karbelle M. non	2	D56	709	5		Febru	iaru 1	3+4-2	2004
		30. Name and address of person who completed cause of death (Item 23a) (	Type, i	Print)				. ·	J	,	
Q		Kachelle Gajadhar, 5505 Hop	ki	29c. License D 56 Print) Bay	vien	s G	rile !	In I for	more 1	NO 213	24
Stat Registra		31. Date filed (Month, Day, Kadr)  FEB 1 4 2006  32. Registrar's Signature	A	rede !							

		•	For State Registrar	tate of Mai	ryland	d / Depa <i>Cei</i>	artment of F	lealth : Death	and Me		giene () Reg. No.	06	04160
- 1	Physicia	an	Decedent's Name (First, Middle, Last)  TEAN TOTALLAND COO	(TVI)						2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	JEAN LOTHIAN SCO  4a. Facility Name (If not institution, give street				4b. City, Town, o	r I ocation	of Death	Feb.	10 4c Cou	2006	8:40 p. <sup>™</sup>
	Examin	er	Keswick Multi Care				Balti		OI DOLLII			/a	
	Funeral Director		5. Social Security Number  320-40-7864  Usual Residence of Decedent	2  7. Age	(In yrs. Ia	st birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birt (Month, Da Nov. 1		O Birthe	
	yland yland	ŀ	10a. State 10b. County		10c. City	Town or Lo	cation					1	Od. Inside City Limits
	Ba-f st	Director	Maryland n/a		Bal	timore	2						1 □ Yes 2 □ No
	with th	Dire	10e. Street and Number 115 Churchwardens R	and			10f. Zip Code				10g. Citizen		ntry?
	ns 23	Funeral	11. Marital Status 12.	Was Decedent Ev	er in U.S	S. 13. V	21212 Was Decedent of H		rigin? (Spec	afy Yes or No	U.S.	A.	can Indian,
Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland ital Hygiene. of other then "naturel", or items 23a or 28e-f show event, the Medical Examiner must be notified at event.	þ	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ∐Yes 2 XNo If Yes, Give Year or Dates:	)	1	fYes, specify Cuba I□Yes 2∑XNo	Specify:	n, Puerto R	lican, etc.)		llack, White,	<sub>⊎tc.</sub> White
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д 2	0 - 0 -	BeC	17. Father's Name (First, Middle, Last)			ПОП	nemaker	18. Moth	er's Name	(First, Middle,	Maiden Sum	home ame)	
ylar	2 should be filed withir and Menta! Hygiene. is marked other the aumatic event, the Ma	To	William		Loth	ian		Agr	nes			eith	
Mar	12 sh h and 7 is m traum		19a. Informant's Name/Relationship (Type, David Scott (Husband				g Address (Street				-		
ē,	Heelth Heelth tem 27 other tr		20a. Method of Disposition	.,		ace of Dispo	hurchward		Koad .			cy Land n - City or To	
OE I	Pages nent of I int: If its iry or o		1 ØBurial 2 ☐ Cremation 3 ☐ Remarks 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		metery, cren norial	natory or other plac Park		2-18-0	06	Skoki		
Baltimore,	permit. Pages 1 and 2 should be Deperment of Heelth and Menta Important: If Item 27 is marked any injury or other traumatic events.		21. Signature of Funeral Service Licensee	m0034	-4	22	Name and Addre Mitchell 6500 Yo	ss of Facility L-Wiece ork Re	defelo	d F.H.		•	
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one complicate shock.	ons that caused the	he death	Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory ar	rrest,	rand	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	ENDST?	468	- D	EWEN	TIA	•				Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a	consequ	ence of):							0
8:40PM	74	Jer	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	Corisoqu	ыпса от):							
00	and transii	Examin	Cause (Disease or injury that initiated events resulting in death) Last	5									
00,8			rosuming in usumi Last	Due to (or as a	consequ	ence of):							
Q 687	the the	edical	d		-								
O. Box	ne death certific the ettending pl thed for use as t	Physician/Me	in the past 12 months?	If yes, outcome of 1□Live birth 2 4□Pregnant at ti 9□Unknown	Fetal	death 3	Ectopic pregnancy Other (specify) _	′				Date of delive Month	ery Day Year
S, P.	\$ 60		Part II. Other significant conditions contrib	uting to death but	not resu	lting in the u	nderlying cause giv	en in Part	l.	23e. Did to	obacco use c	ontribute to t	he cause of death?
rds	w requires been sign should be	ed by	Urinary Tractin	Pector	<u>مر ۲</u>	ECUI	rent			10	Yes 2□No	3 ☐ Prot	bably 4 Unknown
A N Reco	e taw has b	ompleted	U		· ·					24a. Was autor perfo	osv	b. Were auto prior to co death? 1 \(\sum \text{Yes}\)	ppsy findings available impletion of cause of
ia (n	cian: The ertificete octor, pag	BeC	25. Was case referred to medical examiner?		Sale -			26. Place	e of Death	Check only o		103	20110
75	T - 10 11	٤	1 □ Yes 2 No Hosp	1   Inpatient		R/Outpatien		4 PUN			dence 6 🗆		( <b>y</b> )
-ou	B - Age 2	ē	1 Natural 5 Pending 2 Accident investigation	8a. Date of Injury (Month, Day	Year)	Injury	Wor	ya≀ k? Yes 2.⊡		sa. Describe i	how injury occ	curred	
Divisi	9 # 5 E	Certifica	2 Cuicido 6 Could not be	28e. Place of Injur building, etc.	y - At hor (Specify)	me, farm, str	eet, factory, office		2	8f. Location (3 City or Tox	Street and Nu wn, State)	mber or Rura	al Route Number,
S	fo the Hospital within 24 hours e to the Funers! I completely filled	Medical C	29a. Certifier 112 Carti ving Physici (Check only one) 2 Medical Examiner:	an: To the best of On the basis of e and manner state	xamınati	viedge dealt on and/or in	vestigation, in my o	na data a pinion, dea	nd place a ath occurre	nd due to the d at the time,	cause(s) and date and place	e, and due to	tated the cause(s)
	To the within 2 To the comple	ž	29b. Signature and title of certifier		^		29c. Licens				29d. Date sig	ned (Month,	Day, Year)
	7		exerdel!	Dall	le	-	7)9	564	r3	(	02/1	1/20	06
	D		30. Name and address of person who comp	leted cause of dea	ath (Item	23а) (Туре,	Charles			Pros	to Mi	) a	1204
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 4 201	32. Ragistrar	's Signat	ure	arile .	4	wy	بحد.	- 12		

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** FEBRUARY 3:00PM JUNE SCUTI 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A HOSPITAL HARBOR ENTER BALTIMORE CITY If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) June 19, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** 1 M 2 M F 71 1934 Maryland Director 235 52 1373 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic event, the Mcdical Examinar triust for motified at 1 ☐ Yes 2X No Marvland Baltimore Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. 4704 Washington Blvd. 21227 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: þ 3 XWidowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th Coltege (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other freumatic event, the Monge. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John Durst Nellie Rutter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4704 Washington Blvd. Baltimore, Maryland 21227 Craig Scott / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Baltimore, Maryland 2/10/2006 ' 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Gonce Funeral Service, P.A. 21. Signature Funeral Service License 22. Name and Address of Facility 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the san. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final COR PULMONALE. **Physician** YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ATRIAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine death certificate be executed the attending physician and hed for use as the burial-transit YEARS INSUFFICIENCY KENAL resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, 24EARS HYPOUENTILATION SYNDROME OBES Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy 2 Fetal death Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No rector, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 20 No 2 1 🗌 Yes 1 Mipatient 2 ER/Outpatient 3 DOA ŧ 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After Division Injury Natural 5 Pending 1 Yes 2 No 2 Accident investigation the 1 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified KS 000 Mb FEBRUARY 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMURE, MARYLAND, 21225 ABDUL ADJEI 3001 S. HANOVER SI 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 4 2006 Registrar

Registrar

DHMH 17 Rev 1/2001

Book & Speile

Amend item#20b, perfH, C852, 2/14/06 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day of Year Month **Physician** FEBRUNY 3:50 AM SILVER 2006 MARGARET /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SINAI HOSPITAL OF BALTIMORE BAITIMURE N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. AUG. 25, 1925 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 ☐ M 2 🔽 F 231-24-0437 80 Yrs Director V٨ Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show other treumatic avent, the Mcdical Examinar must be notified at 1 ☑ Yes 2 ☐ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5803 HIGHGATE DRIVE 21215 USA or Items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No If Yes, Give 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: WHITE Š If Yes, Give Year or Dates: 3 X Widowed 4 □ Divorced 'natural', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ELECTRONICS ASSEMBLER **ELECTRONICS** permit. Pages 1 and 2 should be file.
Department of Health and Mental Hy
Important: if Item 27 is marked othe
any injury or other treumetic avent,
once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CULLOP DAVID BESSIE BARNSCOME 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL SILVER / SON 9639 HICKORY HURST DRIVE - BALTIMORE, MD 21236 13<sup>Date</sup> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LAKEVIEW MEMORIAL PK 02/12/2006 SYKESVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician LING CANCER Now SMAIL COIL MONTH /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires thet the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Ø Yes 2 □ No 3 □ Probably 4 □ Unknown Completed Pull ONARY HYPERTENTION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ANEMIA certificete 1 Yes 2 No 1 Yes 2 No or Attending Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Z Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 February 9,06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W Beloedere Ave, BAHANO MD, 210 M-1) SINAL HOSPITAL OF NWANKWO BAITIMORE 4 2006 32. Regular's Signature 31. Date filed (Month, Pay-Year) State Registrar

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			1 - For State Registrar		Marylan		artment of rtificate of		d Mental H	ygiene Reg No.	1111	04164
	Physici	an	1. Decedent's Name (First, Middle (N)   LL   A M	e, Last)		-7.1	HOMAS		2. Date of D Month FEBRUA	Day	Year ZOO6	3. Time of Death 4:30 P M
	/Medio		4a. Facility Name (If not institution	n, give street and numl	ber)	1 1		or Location of D		4c.	County of Death	
	Exami		NORTH WEST				RAN	PACCET	UND	E	BALTI,	MORE
	Funeral		5. Social Security Number	6. Sex 7. 1 ☑ M 2 ☐ F	. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	r If Under 24 I Hours N	Hrs. 8. Date of B (Month, D 02/01/	irth Day, Year)	9. Birth	place (State or Foreign intry)
	Director		231-03-4757 Usual Residence of Decedent		90	113.			02/01/	1916	Geo	rgia
	inyland thow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	8e-fs	Directo		timore		Randa	11stown	-				1 ☐ Yes 2 ☒ No
	with the		10e. Street and Number 3714 Live Oak	Pond			10f. Zip Code	133		10g. Citi	zen of What Cou	intry?
	death ms 23	Funerai	11. Marital Status	12. Was Deced		.S. 13. V			? (Specify Yes or Nuerto Rican, etc.)	10-	14. Race - Amer	ican Indian,
36	filed within 72 hours after death with the Maryland Hygione. ther than "natural", or Itams 23a or 28e-f show ent, It e M. Jical Exhalter and be notified at	by Fur	1 ☐ Never Married 2 🛣 Man 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	X□No		fYes, specify Cu 1 □ Yes 2 🛣 No		uerto Rican, etc.)		Black, White Specify: B1	, etc. Lack
Š	2 hou	ted	15. Deceden	it's Education		16a. Deced	dent's Usual Occu	pation	weddiag	16b. Ki	nd of Business/I	ndustry
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ary	should be and Menta e marked umetic ev	1	19a. Informant's Name/Relations	hip (Type, Print)		19b. Mailir	ng Address (Stree	1	Rural Route Num	ber, City o	r Town, State, Zi	p Code)
	es 1 and 2 should to of Health and Ment I Item 27 le marked r other treumetic		Roslyn McMiller	/ Daughte	r	3714 1	Live Oak	Rd., Ra	ondallsto Date	wn.	Maryland	21133
<u>o</u>	Pages 1 nent of H nnt: If Iter iry or oth		20a. Method of Disposition 1      Burial 2 □ Cremation	3 □Removal from St	ate	emetery, cren	natory or otner pi	102	110/2006			
Baltimore,		1	' 4 ☐ Donation 5 ☐ Other (S		Kii	_	orial Pk	· ocme		CULL.	imore, M	f/H, P.A.
Ra	permit. Departr Importe any Inj			J.C. 8								land 21215
I			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that our	sed the death th line.	h. Do not ent	er the mode of dy	ing, such as care	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		EM		TIA					Oriset and Death
r	Examiner			Due to (or	r as a conseq	uence of):						
7	ק ב	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. — Due to (or	r as a солѕеф	uence of):						
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99	ntiticate ng physi as the l	60	IC CCMALC.									
ROX	eath certitic attending p	ian/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		h 2 ☐ Fetal	Idéath 3□	Ectopic pregnan	ру		2	23d. Date of delive	very Day Year
	the de y the a ched t	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnar 9☐Unknow	nt at time of di vn	eath 5∟	Other (specify)					,
 J	res that the de signed by the a be detached t	by Pr	Part II. Other significant condition		th but not res	ulting in the u	nderlying cause g	ven in Part I.	23e. Did	l tobacco u	se contribute to	the cause of death?
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a H	iclen: The lav certiticate has rector, page 2 a								1 ☐ Yes		death?	2 No
<b>=</b>	ysiclen: is certitic director,	o Be	25. Was case referred to medica examiner?  1 Yes 2 No	Hospital: 1 Ving	nationt 2	ER/Outpatien	1 3 DOA 0	hor	Death (Check only		S □Other (Spec	ifu)
ס ר	ding Phys h. After this funeral dir	n: T	27. Manner of Death	28a. Date of		28b. Time of Injury			28d. Describe			
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Division	el or Attens s atter deatl sl Director: ed in by the	Certification:	4 Homicide determ	ined 28e. Place of building	f Injury - At ho g, etc. <i>(Specif</i> )	ome, farm, str	eet, factory, office	•	28f. Location City or T	(Street and own, State	d Number or Rur }	ral Route Number,
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	7		30. Name an address of person CEONARP RICHAR					D RAND	ALLSTOWN	MO	21133	
	Sta Registr		31. Date filed (Month, Day, Year)	6-1	gistrar's Signa		ale .	1				

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			For State Registrar		State of Ma	aryland / i	Certificate				Reg. No.	04165
	2		Decedent's Name	(First, Middle, La	st)					2. Date of Dea	ith	3. Time of Death
	Physici /Medic		LINW	00D	Tin	1MON	S			FEBRUAF	RY /0, 2006	1348PM
	Examin		4a. Facility Neme (If r	not institution, giv				Town, or Locatio	on of Death		4c. County of Death	1
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	Funeral		5. Social Security Nui	mber 6. S	ex 7. Ag	e (In yrs. last bi	rthday) If Under Months	Days Hour	ler 24 Hrs. s Min.	8. Date of Birth (Month, Day JUNE 1	y, Year) 9. Birth	nplace (State or Foreign
	Director	-	Usual Residence of D			TU				V4100 11	6,1437	712
	ylanc how		10a. State	10b. County	1	10c. City, Tow	m or Location					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
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	72 hours after death with the Maryland naturel', or Itams 23a or 28a-f show itsal Examinet must be notified at	Funeral Director	10e. Street and Num		KLINTOWN	100	10f. Zip	Code			10g. Citizen of What Co	untry?
	ns 234	eral	11. Marital Status	, FFANI	12. Was Decedent	Ever in U.S.	13. Was Deced	lent of Hispanic	Origin? (Spe	cify Yes or No-		
(0	r Itan	표	1 Never Marrie	d 2 Married	Armed Forces?	/		lent of Hispanic of Cuban, Mexic		Rican, etc.)		o, etc.
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Maryland	2 should be and Mental is marked of raumatic av		19a. Informant's Nar							_	r, City or Town, State, Z	
	l and lealth im 27 her tr		ESSIE 7		. Sister		526 Will	LMINGI	ION AL	IE. DA	1to. MD 216	
יסנ	or of			Cremation 3	Removal from State	cemete	of Disposition (Namery, crematory or of	ther place)	1 19	8-01	BAlto. 1	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel", or Itams 23a or 28a-f show any injury or other traumatic avant, its Marical Examinar must be notified at any injury.		4 □ Donation :	5 Other (Special neral Service Lice	- 1	IM 1.						
Ba	Depa Depa Impo Any in		Michi	rel Se	Sei		Change	2579 1	FreDer	-ink An	E BAHO, M	0.21229
			23a. Part1. Enter the	e disease, er com	plications that cause one cause on each li	the death. Do	not enter the mod	e of dying, such	as cardiac o	r respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (F	inal	AA.		1 WOU.					Onset and Death
	/Medical Examiner		resulting in death)	(		a consequence						
,		e.	Sequentially list con	ditions,	b. — Due to (or as	a consequence	of):					
/	uted d ansit	Examin	Sequentially list con if any, leaving to im- cause. Enter Under Cause (Disease or in that initiated events	tying njury	С.							
ó	be executed ician and burial-transif		resulting in death) La	ast		a consequence	of):					
8760	8 y 6	lical			d							
x 68	eath certificat attending phy I for use as th	Physician/Med	IF FEMALE:		23c. If yes, outcome	of pregnancy					23d Date of deli	von.
Box	atten for us	cian	23b. Was decedent in the past 12 n	nonths?		2 Fetal deat	h 3 ⊟Ectopic pr 5 ⊟ Other (sp				23d. Date of deli Month	Day Year
P.0.	at the de by the a tached	hysl	1 ☐ Yes 2 ☐ 9 ☐ Unknown	INO	9□ Unknown							
Ç.	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as th	by P	Part II. Other signific	cant conditions	contributing to death t	out not resulting	in the underlying c	ause given in Pa	art I.		obacco use contribute to	
ord	w require been sig should b	ted								1 D Y	res 2 o 3 □ Pro	obably 4 Unknown
Vital Records,	law r nasbe e 2 sh	Completed								24a. Was autop	an 24b. Were au prior to c rmed? death?	topsy findings available completion of cause of
a H	siclan: The law certificate has t irector, page 2 s									Yes	2□No 1 Yes	2□ No
V:t	Physiclan: this certification of the control of the	o Be	25. Was case referrence examiner?		Hospital:	ent 2 ER/O	utpatient 3 DC	100		(Chéck only o	dence 6 Other (Spec	SIEJE
of	g Physie ter this heral di	<b>-</b>	27. Manner of Death	1	28a. Date of Init	ırv 28b.	Time of 2	8c. Injury at Work?			now injury occurred	
ion	£ 2 5 5	atlo	1 □Natural 2 □ Accident	5 Pending investigation	~ II G I	1 C. V. J	339 M	1 ☐ Yes 2	No	SUB	JECT WV	BSHOT
Division of	or Attender the Director in by the	rific	3 ☐ Suicide 4 Homicide	6 □ Could not to determined	28e. Place of in	jury - At home, f ic. (Specify)	arm, street, factory	y, office	2	City or Tou	Street and Number or Ruyn, State) (-23 N	
Ω	urs af urs af aral D	Ce	00- 0	4 C 0 - 1/4 D	businism To the busin		770	ne		FRANK	LINTUNN RD	BALTIMUREN)
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	29a. Certifier (Check only one)			f examination a					cause(s) and manner as date and place, and due	
	To the within 2 To the comple	Me	29b. Signature and	title of certifier	10			c. License numb			29d. Date signed (Monti	
			•	1//	1n			OCV	NE		FEBRUARY	11,2006
	3		30. Name and addre	s of person who	completed cause of	death (Item 23a	(Type, Print)				FEBRUARY 17, mont, m	21201
	9		21 Data filed (15-	MARY	G. (1188	rar's Signature	111	PENN	STRE	ET BA	LTIMONE, M	VARYLYND
	Sta Regist		31. Date filed (Mont		2006 32. Habist	ar s aignature	Spark	,				
	N \$1											

		1	For State Registrar	State of Ma	•	epartmen Certificat			ınd M		iene 0 0	6	04166
	ysicia	n	1. Decedent's Name (First, Middle, Las ROSE ANNA TI	v ERRY					+	2. Date of Death Month		886	3. Time of Death
¥	Medic amine		a. Facility Name (If not institution, given Baltimore Washin		cal Cent			Location o			4c. County	Anne	Arunde1
Fun Dire	eral ctor		220-36-8037	ox 7. Age □M 2\ F	86 Y	nday) If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, May 26	, 1919	9. Birthp	place (State or Foreign htry) VA
Maryland -f show	led at		Usual Residence of Decedent  10a. State 10b. County  MD Anne A	Arundel	10c. City, Town	_	ern					1	0d. Inside City Limits 1 ☐ Yes 2X No
with the	De not	ā	10e. Street and Number			10f. Zip	Code	011/	,	10	Og. Citizen of W		
Iore, Maryland 21215-0036 ges 1 and 2 should be lifed within 72 hours after deeth with the Maryland at of Health and Mental Hygiene. If itsm 27 is marked other than "natural", or itsms 23s or 28s-1 show	xaminer must	by Funeral	844 Stevenson Ro  11. Marital Status  1  Never Married 2 Married  3XXWidowed 4 Divorced	12. Was Decedent I Armed Forces? 1 ☐ Yes 2XXX If Yes, Give Year or Dates:		13. Was Deced If Yes, spec		2114 spanic Orig n, Mexican Specify:		cify Yes or No- Rican, etc.)		k, White,	ean Indian, etc.
Baltimore, Maryland 21215-0036  Depertment of Health and Mental Hygiene.  Depertment of Health and Mental Hygiene.	he Medical E	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12)	ucation		Decedent's Usua Give kind of wo life. DO NOT us	rk done d	during most  )	of working	ng	16b. Kind of Bu	siness/In	
Maryland 2121 2 should be filed within 1 and Mental Hygiene. 1s marked other then '	itic svant, E	To Be Co	17. Father's Name (First, Middle, Last)  Douglas Duff		1	11011	lemak	18. Mothe		(First, Middle, M	Maiden Sumam		Home
Maryla d 2 should th and Men 7 is marke	trauma	1	19a. Informant's Name/Relationship (7 Mr. Lonza Terry			Mailing Address 44 Stev				Route Number, Severn,			
imore, M Pages 1 and 2 nent of Health	or other	9	20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of cemetery	Disposition (Nar crematory or o	ne of other place	θ)	D	ate 2	20c. Location - (	City or To	own, State
Baltimol permit. Pages Depertment of Important: If it	any injury pnce.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen		H111cre M01357	st Mem. 22 Name ar	nd Addres	s of Facility	у	3/2006 Singleto Glen l		ral :	Home, P.A.
Geath certificate be executed BW BW BW BW BW BW BW BW BW BW BW BW BW	ine porial-transit	cal Exar	23a. Part1. Enter the disease, or compands of the property of	Due to (or as b.	a consequence o	Mar 2 n:		1 4		respiratory arre	sst,		Approximate Interval Between Onset and Death
Box 6 ath certif	for use a:	-	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death	3 ☐ Ectopic po 5 ☐ Other (sp					23d. Date Mor		ery Day Year
rds, P. quires that t n signed by	De d	Ď	Part II. Other significant conditions of	ontributing to death b	ut not resulting in	the underlying o	ause give	en in Part I.				ibute to ti	he cause of death?
Re IThe Iar	page 2 should l	Completed				····				24a. Was an autops perform	ned?// d	Vere autorior to coleath?	posy findings available impletion of cause of
of Vita Physician: this certific	rector,		25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 2 npatie	int 2 ER/Out	patient 3□ D0	Othe	~=		Check only one		or (Canad	5.1
ision of Attending Phy r death ctor: After this	funera	H	27. Manny of Death  1	28a. Date of Inju (Month, Da	ry 28b. T		28c. Injury Work		2	28d. Describe ho			<b>y</b> )
Division all or Attenda s after death	ad in y the	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, far c. (Specify)	m, street, factor	y, office		2	28f. Location (Sti City or Town		er or Rura	al Route Number,
To the Hospital within 24 hours	sompletely filled in y	edical	(Check only 2 Medical Exam	ysician: To the best niner: On the basis of and manner sta	examination and	Vor investigation	, in my o	pinion, deal	th occurre	ed at the time, da	ate and place, a	ind due t	the cause(s)
To the within To the	шоз	Ž	29b. Signature and title of certifier  Labour C.  30. Name and address of person who come to the company of the	With	M M.	D. 296	D 4	number 136	5	E	ebruar	(Month,	2006
le C			George E, Wic	completed cause of d	eath (Item 23a) (	Type Print)	tal	Drive	, 6L	en Bur	nie, M	D, &	11061
Re	Sta egistra	te	St. Date filed (Month, Day, 16a)	32. <b>Rogi</b> str	ar's Signature	paile	P						

Terry Ruseanna

		•	For State Registrar	State of Maryla		artment of F rtificate of			giene Reg. No. 006	04167
	Physicia	an	1. Decedent's Name (First, Middle, Last)			, 4993		2. Date of De		3. Time of Death 2126 2:55F/m
	/Medic		Genevieve B. Ta			4. Ch. T.		*	4c. County of I	
	Examin	er	4a. Facility Name (If not institution, give s Saint Joseph	Medical Ce	nter	4b. City, Town, o	То	WSON	В	altimore
	Funeral		5. Social Security Number 6. Sex	M 21X1F	s. last birthday) Yrs.	If Under 1 Year Months Days		Vin. (Month, Da		Birthplace (State or Foreign Country)
	Director		215-14-4222 Usual Residence of Decedent	84	113.			Sept 2	1, 1921	Maryland
	yland yland		10a. State 10b. County	10c. (	City, Town or Lo	ocation				10d. Inside City Limits
	e-fat	ctor	Maryland Baltimo	re	Parkv	ille				1 ☐ Yes 2 🛣 No
	or 28	Directo	10e. Street and Number			10f. Zip Code			10g. Citizen of Wha	at Country?
	ath w	rai	8800 Walther Blvd	<ol> <li>apt. 260:</li> <li>Was Decedent Ever in</li> </ol>		Was Decedent of h		? (Specify Yes or No	USA 14 Bace	American Indian,
	item item	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 X No	0.3.	If Yes, specify Cub	an, Mexican, P	uerto Rican, etc.)		White, etc.
5-0036	ursal	by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Specify:	White
5-0	within 72 hours after death with the Maryland ene. Than "natural", or Itama 23a or 28e-f ahow ta Madical Examinar must ka ricilifical at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occup	during most of	working	16b. Kind of Busin	ness/Industry
2	vithin ne. han	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	•		D o o o lo o	! a
D	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)	n/a		Secretai		Name (First, Middle,	Bank: Maiden Surname)	ing
aŭ	ld be ental ked o	To Be	John Thomas	Buri	nham		Rut	h Ade	ele 1	Blucher
Maryland 2121	es 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Metal Hygiene, and filem 21s and 28e-1 ahow filem 21s marked othar than "natural", or itama 23a or 28e-1 ahow riem 21s marked othar than "natural", or itama 23a or 28e-1 ahow riem 21s marked othar than "natural", or the recommendation of the control	-	19a. Informant's Name/Relationship (Ty)			ng Address (Street	and Number o	or Rural Route Number	er, City or Town, Sta	ate, Zip Code)
2	1 and 2 Health em 27 i		Eleanor Helen Rol					d, Reister		
Ψ.	Pages 1 nent of H int: if ite iry or oth		20a. Method of Disposition 1 ☑Burial 2 ☐Cremation 3 ☐R	emoval from State	cemetery, cre	osition (Name of matory or other pla			20c. Location - Cit	
Baltimore,	it. Par ritmen ritent: njury		4 □Donation 5 □ Other (Specify)	A 6		Cemetery 2. Name and Addr		b 7, 2006	Lutherv	ille, Maryland
Bal	permit. Pages Department of Important: If It any injury or o		Bryan W. Clark	lary	)	Lemmon Fu 10 W. Pac	ineral lonia R	Home of Du oad, Timor	nium, MD	21093
	Pnysician		23a. Par . Enter t e disease, or compli shrick, or hea . failure. List only or Immedia e Cause (Final disease y condition	cations that caused the de ne cause on each line.			ng, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between Onset and Death
	/Medical Examiner		disease a condition resulting in death	Due to (or as a cons	equence of): AORT:	IC STEN	DSIS			
		ner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying	Due to (or as a sons	equarica of):					
V	death certificate be executed e ettending physicien and ad for use as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):					
8760,	sicien burial	alE			34301103 317.					
687	ifficate g phy: as the	Physician/Medical								
Вох	th cer tendin r use	an/N	23b. was decedent pregnant	3c. If yes, outcome of pred 1 ☐ Live birth 2 ☐ Fo	etal death 3	□Ectopic pregnanc	ÿ		23d. Date of Month	,
<u>.</u>	e dea the ett hed fo	sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant at time o 9□Unknown	f death 5	Other (specify)			Mona	. 22,
P.0	law requires that the death certifica as been signed by the ettending pl 2 should be detached for use as I	, Ph	Part II. Other significant conditions cor	ntributing to death but not r	esulting in the i	underlying cause gr	ven in Part I.	23e. Did 1	tobacco use contrib	ute to the cause of death?
Records,	quires that n signed t	d by						1	Yes 2 No 3	Probably 4 Unknown
O O	aw requir as been si 2 should	plete						24a. Was	an 24b. We	are autopsy findings available or to completion of cause of
Œ	The lavate has	Completed						perfo 1 ☐ Yes	ormed? dea	ath? ]Yes 2 <b>X</b> No
Vital	ysician: The lis certificate hadirector, page	Be	25. Was case referred to medical examiner?	loonital.		100	hon	Death (Check only		
of	Physician: this certific ral director.	5	1 ☐ Yes 2 No	lospital: 1 X Inpatient 2 28a. Date of Injury	ER/Outpatie	III 3 DOA		ing Home 5 Resi	how injury occurred	
O	ding h. After funel	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year,		We	ork? ]Yes 2∐No		,,,,	
Division	or Attending after death. Director: After in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, si ecify)	treet, factory, office	)		(Street and Number wn, State)	or Rural Route Number,
_	To the Hospitel or Attanding Ph within 24 hours after death. To tha Funeral Director: After th completely tilled in by the funeral	edical C	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my liner: On the basis of exame and manner stated.	knowledge, dea ination and/or i	th occurred at the nvestigation, in my	ime, date and opinion, death	place, and due to the occurred at the time,	cause(s) and mann, date and place, an	ner as stated. d due to the cause(s)
	To the within 2 To the comple	Med	29b. Signature and title of certifier	and mariner stated.		29c. Licer	se number		29d. Date signed (	Month, Day, Year)
	- s + ŏ		Judingu h	Walle L	n-0	D	41410		February	19172016
-	D		30. Name and address of person who co	A			TATA TILE	Tr (T) 100 (T) 1.1	MODVION	ID 21204
	St.	ate	31. Date filed (Month, Day, Year)	HTA, M.D., 32. Registrar's Si			DKIAE	TOWSON,	MARYLAN	1.1./ L. J. L. 4.3 -T
	Regist		FEB 1 4 20	06	1 A	sale)				

DHMH 17 Rev 1/2001

ORIGINAL

			For State Registrar		State	of Ma	ryland		artment rtificate				lental Hy	Reg. No.	0(	) 6	04168	
			1. Decedent's Name	(First, Middle	Last)								2. Date of D Month	eath Day	,	Year	3. Time of Death	
	Physici /Medio		RITA	ANNA	THORN	TON							Februa		1 20		12:00p M	
	Examir		4a. Fecility Name (If		=				, ,		Location of	of Death				of Death		
					MORE MED				TOWS		If Under	24 Hes	0.0		ALT'	MORE		
	Funeral		5. Social Security No		6. Sex 1 ☐ M 2 🖫 F	7. Age	(In yrs. las	it birthday) Yrs.	Months		Hours	Min.	8. Date of B	irin ay, Year) E 1.0	11/	9. Birthi Cou	place (State or Foreign htry) yland	3
	Director		214-01-34 Usual Residence of				91						June 1	), I	914	riai	yranu	
	Maryland -f show		10a. State	10b. County			10c. City,	Town or Lo	cation								Od. Inside City Limits	
	Mar.	ţċ	Maryland	Balti	more		7	Cowso	า								1 ☐ Yes 2 XNo	
	with the a or 28a	irec	10e. Street and Num	nber					10f. Zip	Code				10g. Citi	zen of V	Vhat Cou	ntry?	
	23a c	by Funeral Director	409 Virg	ginia A	venue					212	286				U.	S.A.		
	r death	Inel	11. Marital Status		12. Was De Armed F	orces?		13.	Was Deced If Yes, spec	ent of Hi rfy Cuba	spanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or N Rican, etc.)	0-		e - Ameri k, White,	can Indian, etc.	
98	hours after tural, or ite	y Fi	1 Never Marrie 3 XWidowed		ed 1 Tyes If Yes, 0 Year or	2 XN	0		1 ☐ Yes 2	No X	Specify:				Specify	. Wh	ite	
Š	tural tural		3 A WIGOWAG	15. Decedent		Dales.		16a. Dece	dent's Usua	Occupa	ation			16b. Ki	nd of B	usiness/Ir		_
Z rç	within 72 to one. than "net the Medice	Completed		ify only highes	t grade completed	(1-4or 5-		(Give	kind of wor DO NOT us	k done a	furina mos	t of work	ing				,	
5	iene r the	Eo	10 year		College	(1-401 54	+)		(	ler	k			Der	oart	ment	Store_	
È	other other	BeC	17. Father's Name (	First, Middle, I	ast)						18. Mothe	er's Nam	e (First, Middle	e, <i>Maid</i> en	Suman	ne)		
Maryland 21215-0036	is to year of the filed value of the marked other transmatic event, in	10E	Patrick		King						Mar	gare	et	N	<u>1cHu</u>	gh		
2	and le mu		19a. Informant's Na	me/Relationsh	ip (Type, Print)								al Route Numi	-				
			Rita Cai		_(daught	er)	OOh Die	9729	Harve sition (Nam	ster	r Cir	cle.	Perry	Hall,	_Ma	ryla	nd 21128 own, State	4
Reltimore	Profit		20a. Method of Disp 1 XBurial 2		3 □Removal from	n State	cen	netery, crei	matory or ot	her plac						•		
<u>.</u>	t. Partmen		4 Donation				Gard		f Fai								aryland	-
	permit. Pages Department of Important: If Its any Injury or o		21. Signature of Fu	neral Service I	Licensee			M	itche	11-W	iede	feld	Funera	1 Ho	me,	Inc.	7.07.0	
1			23a. Part1. Enter	e di ase, or	complications that	2-e t caused	the death.						Itimore or respiratory		ryla	ind 2	Approximate Interval Between	
		ı	shock, or hear Immediate Cause (	rt failure. List	only one cause on	each lin	omo		_	,							Onset and Death	
	Physician /Medical		disease or condition resulting in death)	n	aDue to	o (or as a	a conseque	nce of):			-						weeks	
7,	Examiner	L			An	ter	LOS	cler	th C	ca	rdi	000	sculo	idi	xo	e	years	
20	P =	ner	Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or	nditions, mediate riving	Due to		conseque										0	
9	be executed sician and burial-transit	Examiner	Cause (Disease or that initiated events resulting in death) L		c	,												_
7,00	te be exergistion and burial-	0	rosularig in coulin) i		Due to	o (or as a	a conseque	nce or):										
/ a	\$ \$ \$ B	dical			d													
80	eath certificat attending phy	/Me	IF FEMALE:	orognon!	23c. If yes, c										23d. Da	te of deliv	erv	
à	Beath atter	ciar	23b. Was decedent in the past 12 1 2 Yes 2	months?			2 ☐ Fetal d time of dea		Ectopic pro Other (spe						Мо	nth	Day Year	
) (	that the de	hysi	9 Unknown		9□ Unk	nown												
120	The Collus, T.C. BOX of the law requires that the death certificatie has been signed by the attending phoage 2 should be detached for use as it.	Completed by Physician/Med	Part II. Other signif	icant condition	ns contributing to	death bu	it not result	ing in the u	nderlying ca	use give	en in Part I		23e. Did	tobacco (	ise cont	ribute to 1	he cause of death?	
	v requires: been signi	ed	CONC	estiv	res nec	ut	_ t	ano	ni				1	Yes 2	□ No	3 Pro	bably 4 SUnknown	
9	e lawre has be	pie	ehron	110	renal	. 11	-we	Fich	encu	V			24a. Wa	s an opsy	1.	prior to co	opsy findings available impletion of cause of	•
0		Com								$\langle \rangle$			per 1 ☐ Yes	formed? 2 X No		death?	2 □ No	
ار الح المؤالا	VILC Blotan: centific rector,	Be	25. Was case referrexaminer?	red to medical	Manager 1	,				100		of Deat	th (Check only	one)				
0 3	Physic Physic rthis o	မ	1 Yes 25		Hospital:	Inpatier e of Injur		P/Outpatier			4 14	ursing Ho	ome 5 ☐ Res 28d. Describe	sidence			fy)	_
		lon	27. Manner of D att	5 ☐ Pendin investic	g (Mo	onth, Day	Year)	8b. Time o Injury	M	Bc. Injury Work	γαι ∢? Yes 2□	No	280. Describe	now injui	y occur	rea		
4 3	204	ertification;	2 🗀 Accident 3 🗋 Suicide	6 ☐ Could r	ot be 28e. Pla	ce of Inju	ry - At hom	ne, farm, st	reet, factory			-				er or Rur	al Route Number,	
9	lor At after of Direct	erti	4 🗌 Homicide	determ	bui	lding, etc	c. (Specify)		,	,			City or To	own, State	)			
F	Hospital or 24 hours afte Funeral Dir	edicai C	29a. Certifier (Check only one)		g Physician: To t Examiner: On the		examination											
/	To the Hos within 24 h To the Fur completely	Med	29b. Signature and	title of certifier		oi 3tdl			290	License	number			29d. Da	te signe	d (Month,	Day, Year)	-
	FSFO		MY.	ond -	08 1	21	all	lu		0 5	+56	4-	٠	00	1/1	1/2	006	
	10)		30. Name and addr	ess of person	who completed ca	use of de	eath (Item 2	23a) (Type,	Print)		1000		,	0	1	1		
	1		Kendall	RFai	llknern	ND/		S N.	Char	fcs '	8AZ	Urte	203/1	the	to	ND	41204	
	St Regist	ate rar	31. Date filed (Mon	th, Day, Year) FEB 1	4 2006	Retristra	ar's Signatu	re	South	,	1		/					

			1 - For State Registrar	State of I	Marylan		artment of I rtificate of		and Mental	Hygier Reg.	ZUUb	04169
	Physici	an	Decedent's Name (First, Middle, La	· ·	SKA	-			Mon	of Death h ruary	Day 11, 2006	3. Time of Death 6:05 AMM
	/Medio		4a. Facility Name (If not institution, give				4b. City, Town, o	or Location of			4c. County of Death	
	ZAGIIII		EDENWALD				Tows				Baltimore	
A	Funeral Director		217-50-2796	Sex 7. 1 □ M 2 🕅 F	Age (In yrs. 96	last birthday) Yrs.	Months Days	Hours	Min. 8. Date Min. (Mon Sept	of Birth th, Day, Ye 12,	9. Birth Cod 1909 Po	hplace (State or Foreign untry) 0land
	land ow		Usuel Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation					10d. Inside City Limits
	e-feh	ctor	Maryland Baltimo	ore County	У		Towson					1 ☐ Yes 2 🛣 No
	or 28	Funeral Director	10e. Street and Number	1 //20:	1		10f. Zip Code	1286		10g.	Citizen of What Cou USA	
	eath v	eral	800 Southerly F	12. Was Decede		S. 13			oin? (Specify Yes	or No-	14. Race - Amer	
980	72 hours after death with the Maryland natural', or items 23a or 28e-f ehow Jiest Exacutrational be profitted at	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Amed Force 1 Yes 2 If Yes, Give Year or Date	s? ∏No		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		, Puerto Rican, e	c.)	Black, White	
Maryland 21215-0036		Completed	15. Decedent's E (Specify only highest gr.		or 5+)	(Give	dent's Usual Occu a kind of work done DO NOT use retire	during most	t of working	16b	. Kind of Business/l	Industry
121	e filed within al Hygiene. . other then '		9 17. Father's Name (First, Middle, Last	()		Prop	orietor	18. Mothe	er's Name (First, A	Aiddle Maid	Bakery	
au	should be for the state of the	To Be	Peter Biels						ntonte		Zawistask	a
Mary	id 2 silth ar lith ar trau		19a. Informant's Name/Relationship		ew)		ng Address (Street				ity or Town, State, Z aryland	(ip Code) 21015
	Pages 1 annent of Healingt: If item 2		20a. Method of Disposition		20b. P	- Annual Control of the Control	osition (Name of matory or other pla		Date		. Location - City or 1	Town, State
Baltimore,	Page ment cent: if		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci	fy)		1aney	Valley M	em Grd	The second secon	_		n, Maryland
Balt	permit. Pag Department importent: f any injury o			vson			5500_York	Road	. Baltim	ore. I	Home, Inc Maryland	21212
Ē	Physician		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each	h line.	h. Do not en	ter the mode of dy	ng, such as	cardiac or respira	tory arrest,		Approximate Interval Between Onset and Death
13	/Medical Examiner			Due to (or	as a conseq							
3760,	ate be executed: hysicien and he burial-transit	IIcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		USCL juence ol):	-4 40A	_ (1	m 1100	1851 17 17	um.	20 yn(
.O. Box 68760,	death certificate be executed e attending physicien and ad for use as the burial-transit	edical	cause. Enter Underlying Cause (Disease or injury that initiated events	c	as a consequence of pregnance 2 Feta tat time old	uuence ol):  uuence ol):  ancy al death 3[	□Ectopic pregnanc		m 1000	1851 17 17	23d. Date of deliment	
P.O. Box 6	that the death certificate be executed ed by the attending physicien and detached for use as the burial-transit	by Physician/Medical	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 M No	c. Due to (or d. 23c. If yes, outcome to help birth 4 Pregnan 9 Unknown	as a consequence of pregnance 2 Feta tat time of d	uuence ol):  uuence ol):  ancy al death 3[ death 5[	□Ectopic pregnanc □ Other (specify) _	у			23d. Date of delification Month	ivery Day Year the cause ol death?
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			For State Registrar	State of Mary		artment of He		ntal Hygie	4000	041	70
	Physici	an	1. Decedent's Name (First, Middle,	·				. Date of Death Month	Day Year	3. Time of	
	/Medio	cal	4a. Facility Name (If not institution,	James H.	Valent	1ne 4b. City, Town, or Lo			0, 2006 4c. County of Deat	2:30	Рм
nd.	Examir	ier	719 Maiden Choic				nsville		Baltim		
	Funeral		Social Security Number		yrs. last birthday)	If Under 1 Year		Date of Birth (Month, Day, Ye	ar) 9. Birt	thplace (State or	r Foreign
	Director		528-24-5827 Usual Residence of Decedent	A -	80 Yrs.		[A	pril /,	1925 Uta	ah	
	how	L	10a. State 10b. County	10c	. City, Town or Lo	cation				10d. Inside Cit	
	Ba-f	Directo	Maryland Baltin	nore	Catons					1 🗆 Yes	2 <b>\</b> No
	with ti	Dir	10e. Street and Number	- I DD /41	2	10f. Zip Code	2	10g.	Citizen of What Co	ountry?	
	death ms 23	Funeral	719 Maiden Choic	12. Was Decedent Ever	in U.S. 13. \	Was Decedent of Hispa	anic Origin? (Specif	y Yes or No-	USA 14. Race - Ame	ncan Indian,	
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene.  If Item 27 is marked other then "natural", or Items 23a or 28a-1 ehow or other traumatic event, fra Medical Exaction regal for polified at	by Fur	1 ☐ Never Married 2 🔯 Married 3 ☐ Widowed 4 ☐ Divorced		L943 L946	if Yes, specify Cuban, I 1 ☐ Yes 2 🂢 No	Mexican, Puerto Ric Specify:	án, etc.)	Black, White	e, etc. nite	
21215-0036	2 hour	ted k	15. Decedent's	Education	16a. Dece	dent's Usual Occupation	on	16b	. Kind of Business/		
215	ithin 7 19. "n	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	(Give	kind of work done duri DO NOT use retired)	ing most of working			,	
	iled w Hygier ther th	Co	17. Father's Name (First, Middle, La	4	Acc	countant	2 Mathada Nama //		ommercial	Credit	
Maryland	should be find Mental Harked of	To Be	Harland Valenti			18	3. Mother's Name (F Sadie H	irst, <i>middie, m</i> aid irschi	en Sumame)		
ary	s mar	-	19a. Informant's Name/Relationship		19b. Mailir	ng Address (Street and			y or Town, State, 2	Iip Code)	
	and 2 ealth a m 27 ls		Charlotte Valer		719 N	Maiden Choi			Catonsvil	le, MD	2122
lore	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 □ Burial 2 ☒ Cremation 3	☐Removal from State	•	natory or other place)	Date		Location - City or		
Baltimore,	permit. Pages Department of Important: If It eny Injury or o		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice		1100	ematory Inc			ltimore,	Marylar	ıd
Ba	Ded Imp		Thomas Grego	Grego	1_3	Name and Address of MacNabb Fur 301 Frederi	ick Road I	Baltimore	≘. Marvla	nd 2122	28
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	implications that caused the city one cause on each line.	death. Do not ente	er the mode of dying, s	such as cardiac or re	espiratory arrest,		Approximate Interval Betwonset and D	veen
j e	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	1971	Ming Co	avier 1	10 Cgr	rain		- Call
Н	Examiner		Conventielly list and ditions	b Due to (or as a con	isaquarica or):	,					
	pe tisi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	isequence of):						-
<u> </u>	execut n and ial-trar	Exan	that initiated events resulting in death) Last	c Due to (or as a con	sequence of):						
8760,	cate be executed physician and the burial-transit	dicail		d							
9		/Med	IF FEMALE:	020 16 100 0 100 0							
Box	death certifi e attending id for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of deliment		ear
<u>Р</u> .	the de	hysi	9 Unknown	9□ Unknown							
	The law requires that the ite has been signed by th page 2 should be detache	þ	Part II. Other significant conditions	contributing to death but not	resulting in the un	nderlying cause given in	n Part I.		o use contribute to	the cause of de	
Records,	w require been si should b	letec						1 ☐ Yes 24a. Was an			
We.	sician: The law certificate has l rector, page 2 s	Completed						autopsy performed?	prior to c death?	topsy findings at ompletion of car	use of .
Vital		BeC	25. Was case referred to medical examiner?			26	3. Place of Death (C	1 ☐ Yes 2 📝 Theck only one)	vo 1 ☐ Yes	2 L No	
	Physicia this cert al directo	<sup>C</sup>	1 Yes 2 No		2 ER/Outpatient		4 Nursing Home			ıly)	
O	in in in in in in in in in in in in in i	tion	1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day Year	r) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes	28d 2 □ No	. Describe how in	jury occurred		
Division of	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	3 Suicide 6 Could not	be go Blood to	At home, farm, stre			Location (Street City or Town, Sta	and Number or Rui	ral Route Numb	ΘΓ,
Ξ	Hospital or 14 hours afte Funaral Dire tely filled in t										
	• Hosp 24 ho • Funs letely fi	Medical	29a. Certifier 1  Certifying I (Check only one)	Physician: To the best of my aminer: On the basis of exam and manner stated.	nination and/or inv	estigation, in my opinio	on, death occurred a	at the time, date a	nd place, and due	to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	re111. 11d		29c. License nu	ımber	29d. C	ate signed (Month	, Day, Year)	
	11		· YE	rain in		000	2004	2/	10/06		
0	, od		30. Name and address of person wh	o completed cause of death (	Item 23a) (Type, F	29c. License nu DCO Print) Characteristics Characteristics	uce /	en Co	atour	ille.	MA
	Sta	_	31. Date filed (Month, Day, Year)	32 Registrar's Si	ignature	id 1		/	2	122	8
Eg.F.	Registr	ar	FEB 1 4 2	006	S PERSON						

			1 - For Stata Registrar	State of Ma	arytaric		artment of rtificate of		na me		Co U	U b	041/1
				A1		Cei	Tillicate Of	Dealli	10	. Date of Death	g. No.		2 Time of Death
	Physici	an	Decedent's Name (First, Middle, Last)						2	Month	Day	Year	3. Time of Death
	/Media		CLEMENT JOSEPH		SR.					FEBRUAF			
	Examir	ner	4a. Facility Name (If not institution, give	street and number)			4b. City, Town,	, or Location of	Death		4c. Co	unty of Death	
4		0	OAK CREST VILLAGE				PARKV				BA	LTIMOR	
	Funeral		5. Social Security Number 6. Se	ox 7. Age SgM 2□F	e (In yrs. Ia	ist birthday)	If Under 1 Yea Months Day		Min. 8	(Month, Day,		9. Birth Cou	place (State or Foreign intry)
ii-	Director		215-12-3799	<b>X</b> 20.	83	Yrs.			2	/11/192	23	MAR	YLAND
	pug 🔏		Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	ncation						10d. Inside City Limits
	anyle •ho	2	,	D.D.									1 ☐ Yes 2 ☐ No
	8a-f	ctc	MD BALTIMO	RE	PA	RKVILI							
	or 2	ä	10e. Street and Number				10f. Zip Code			10	og. Citizen	of What Cou	intry?
	23s	'Es	8810 WALTHER BLV				2123				US		
	e me	Ine	11. Marital Status	12. Was Decedent E Armed Forces?		5. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Orig Jban, Mexican,	in? (Specir Puerto Ri	fy Yes or No- can, etc.)		Race - Ameri Black, White,	
9	or I	Y.	1 Never Married 2 Married	1 X Yes 2 □ N If Yes, Give			1 ☐ Yes 2 🙀 N	lo Specify:			Sp	ec <i>ify:</i>	
ğ	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23s or 28s-1 ehow Its Moolloel Exa viliar mast be multified at	Completed by Funeral Director	3 Widowed 4 Divorced	Year or Dates:	WWII								HITE
$\frac{1}{2}$	72 h	ete	15. Decedent's Edu (Specify only highest grad	ucation de completed)		16a. Dece	dent's Usual Occ kind of work don DO NOT use retii	supation ne during most	of working	.   1	16b. Kind	of Business/Ir	ndustry
<u>2</u>	Aithin ne.	I di	Elementary/Secondary (0-12)	College (1-4or 5	+)			rea)					
2	be filed within 72 hours after death with the Marylan stal Hygliene. ed other than "natural", or Iteme 23a or 28a-1 show event, the Madical Exp. iling reast to mulfiled at	ပိ		2 YEARS		ACC	DUNTANT	10 Mother	do Nome /	First, Middle, N		Y PROD	UCTS
ב	tal H d otl	Be	17. Father's Name (First, Middle, Last) WILLIAM AUGUST V.	TOVEDS					,	-irst, middie, N E UNKEL		mame)	
<u>X</u>	should be and Menta a marked umatic ev	2											
Maryland 21215-0036	2 2 2 2		19a. Informant's Name/Relationship (T)	ype, Print)		19b. Mailir	ng Address (Stre	et and Number	r or Rural F	Route Number,	City or To	wn, State, Zi	p Code)
	1 and 2 Health tem 27		NAN L. VICKERS/WI	FE			WALTHER	BLVD.	APT				MD 21234
Baltimore,	of H		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F	Removal from State	20b. Pla	ace of Dispo metery, crer	osition (Name of matory or other p	lace)	Dat	e 2	20c. Locati	ion - City or T	own, State
Ĕ	permit. Pages Department of It Important: If It any Injury or of		4 □Donation 5 □ Other (Specify)		MET	RO CRE	EMATORY,	INC.	2/14	/06 c	CATON	SVILLE	, MD
ᆵ	Departi Departi Importi any Inj ance.		21. Signature of Funeral Service Licens	See //		22	2. Name and Add	fress of Facility	THE	JOHNSC	N FUI	VERAL I	HOME, P.A.
m	89 = 9		Heather	Hay			3521 LOC				SON,	MD 2	1286
			23a. Part1. Enter the disease, or complete shock, or heart failure. List only o	lications that caused	the death.	Do not ent	ter the mode of d	ying, such as c	ardiac or r	espiratory arre	est,		Approximate Interval Setween
	Physician		Immediate Cause (Final	O 1									
E. Sant					CARL	. /				4			Onset and Death
100	/Medical		disease or condition resulting in death)	a. Olun  Due to (or as a	a conseque	-	with	100		H			Onset and Death
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	Physici /Medi	al	Decedent's Name (First, Middle, La     FRANCES D. VONKE	NNEN			2. Date of Month FEBRU	Day Year JARY 11, 2006 12:43 A M
	Examir Funeral	er	4a. Facility Name (If not institution, giv  19 MAGNOLIA AVE.  5. Social Security Number 6. S		r) ige (In yrs. last birthday	4b. City, Town, or GLEN BURI If Under 1 Year	NIE If Under 24 Hrs. 8. Date of	4c. County of Death  ANNE ARUNDEL  f Birth 9. Birthplace (State or Foreign
	Director		219-12-3415 Usual Residence of Decedent	□M 2 <b>½</b> F	83 Yrs.	Months Days		8, 1922 MARYLAND
	ath with the Marylan 23a or 28a-f show	Director	10a. State 10b. County  MARYLAND ANNE ARI  10e. Street and Number	INDEL	GLEN BURN			10d. Inside City Limits  1 ☐ Yes 2 ☑ No  10g. Citizen of What Country?
036	or Items	by Funerai	19 MAGNOLIA AVE.  11. Marital Status  1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 [Yes 2] If Yes, Give Year or Dates	? [No	21061 Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	spanic Origin? (Specify Yes oi n, Mexican, Puerto Rican, etc. Specify:	UNITED STATES  14. Race - American Indian, Black, White, etc.  Specify: WHITE
21215-0036	d within 72 giene. er than "na ithe Medic	Completed	15. Decedent's Et (Specify only highest gra Elementary/Secondary (0-12) 12		(Give life.	dent's Usual Occupa e kind of work done d DO NOT use retired EMAKER	luring most of working	16b. Kind of Business/Industry OWN HOME
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	of Health a Item 27 Is other tra		WILLIAM VONKENNED  20a. Method of Disposition  1 X Burial 2 Cremation 3 C	/ HUSBAI	ND 19 M	AGNOLIA A	VE. GLEN BURN	
Baltimore,	permit. Page Department of Important: If any Injury or 2002.		4 Denation 5 Dener (Specifical Signature of Fundral Service Licer	_	2		CEM 2006 S of Facility UDDICK FUNERAL HWY. S.E. GL	
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	ysici Is cel direc	To Be	25. Was case referred to medical examiner?  1  Yes 2	Hospital: 1 ☐ Inpa	tient 2 ER/Outpatie	nt 3 DOA Othe	26. Place of Death (Check or 3r: 4 ☐ Nursing Home 5 1 ℃	esidence 6 Other (Specify)
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Divi	₽ afte		4 Homicide determined	building,	njury - At home, farm, si etc. <i>(Specify)</i>		City or	on (Street and Number or Rural Route Number, r Town, State)
	the Hospital hin 24 hours the Euneral the Funeral upletely filled	edicai	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Exam	niner: On the basis and manner	of examination and/or in	nvestigation, in my op	ie, tate and three and the to pinion, death occurred at the ti	the cause(s) and marrier as stated ime, date and place, and due to the cause(s)
	To t To t	M	29b. Signature and little of certifier	Intra	th	P 29c. License	-40 9 4	29d. Date signed (Month, Day, Year) 2 / 1 3 / 0 6
	6		30. Name and orders of person who	bay M.	(Item 23a) (Type	14dison	bank Drive,	Glen Burnie, md, 2106
	Sta Registi		FFR 1 4 2		and a digitatore	South !		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg No Day Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February **Physician** 2006 2:15 Nellie Holme Van Rossum /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Keswick Multi-Care Center Baltimore If Under 1 Year | If Under 24 Hrs. | Months Davs Hours Min. 8. Date of Birth (Month Day, Year June 29,1910 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🖫 F Maryland 216-14-4344 Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, Its Modical Examination was be notified at 1 Yes 2 No Director Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2525 Pot Spring Road L-323 21093 U.S.A. death v by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 2 should ba filed within 72 hours after on and Mental Hygiene. Is marked other than "natural, or ite 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Art. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nellie H. Lafferty William Van Rossum 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 si nent of Health an 2525 Pot Spring Road L-323 Timonium, Maryland 21093 Doris E. Schmitt-Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ō parmit. Page Department of Important: If any injury or once. 2/13/06 Baltimore, Maryland Parkwood Cemetery Leonard J. Ruck, Inc. Heather Cain 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 5305 Harford Road Baltimore, Maryland 21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final disease or condition resulting in death) Preumonie Physician acura /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate ba exacuted burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical usa as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown ō 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed orosis with multiple com 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed actures apine 2 No 21 No 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 2 No 4 Urursing Home 5 Residence 6 Other (Specify) 1 Yes Certification: To 27. Manne Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Watural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 T Homicide within 24 hours a To the Funerel L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier e GAR (TV) 013657 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 th STREET, BALTITIRE, MD 21211 THERREGOR 700 W

DHMH 17 Rev 1/2001

State

Registrar

LSMBELLE

FEB 1 4 2006

31. Date filed (Month, Day, Year)

**ORIGINAL** 

32 Registrar's Signature

			1 - For State Registrar	State of M	1arylan		artmen rtificat			and M	_	giene Reg. No.	006	04174
	Dhunini		1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	ath Day	Yeer	3. Time of Death
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98	be filed within 72 hours after death with the Marylend that Hygiene. Id other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be notified at	y Funerai	11. Marital Status  1 Never Married 2 Married	Armed Forces 1 Ares 2 If Yes, Give	s? ]No₩₩	11	If Yes, spec			, Puerto F	city Yes or No Rican, etc.)		Black, White	e, etc.
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Maryland 21215-0036	permit. Pages 1 and 2 should be to Department of Heath and Mental Important: if item 27 is marked or any injury or other traumatic evenore.	To Be	David Edward Fran		ter						de Aug		,	er
lan	2 sho		19a. Informant's Name/Relationship (7	Type, Print)							Route Number			(ip Code)
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Baltimore,	or of H		20a. Method of Disposition 1 Å Burial 2 □ Cremation 3 □	Removal from Stat		Place of Dispo cometery, crea	natory or o	ther place			ate		tion - City or	
Ë	ment mant:		`4 □ Donation 5 □ Other (Specify	1)	Sn	ydersb	urg C	h. C	em. F	eb.	16,200	5 Sny	dersbu	rg, Md.
3a II	Depart Import Import In In In		21. Signature of Funeral Service Licen	500)		27 E	2. Name an	d Addres	s of Facility	1 Ch	apel, I	P.A.		
_	70 E 4 9		23a. Part1. Enter the disease, or com	leaudy	•	3	295 C	harm	il Dr	M	anches	ter. I	Md 21	L02
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	plications that cause one cause on each	ed the deat line.	h. Do not ent	er the mod	e of dying	g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· Coron	m-	Opder	~ D	1366	<b>&gt;</b> 2					Onset and Death
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	be slt	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):								
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E F		S									1 Yes	rmed? 20 No	death? 1 🗆 Yes	2 No
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Ē		ertification;	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Pay Year)	28b. Time of Injury		8c. Injury Work			8d. Describe I	now injury o	occurred	
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)	de		> Heyd Hols	I, M	).			DE	1033	55	27.	211	3/01	
3	01		30. Name and address of person who	completed cause of	death (Iten	n 23a) (Tvpe.	Print)		- 77			J.//	711	57
1			29b. Signature and title of certifier  September 29  30. Name and address of person who can be plen Si  31. Date filed (Month, Day, Year)	Horsh.	m	0 91:	Wa	5/4.	1-19-	RI	(1100	Im hi	5101 /	nd
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		•	For State Registrar	State of M	Maryland / Depa	artment of F			giene Reg. No. 06	04175
	4.7.		1. Decedent's Name (First, Midd	le, Last)				2. Date of Dea	Day Year	3. Time of Death
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100	- E	Áth -	1306 GLENMONT		Ass (In use look hirthdou	TOWSO	If Under 24 Hrs.	8. Date of Birt	BALTIM	IORE thplace (State or Foreign
	Funeral		5. Social Security Number	6. Sex 7. A	Age (In yrs. last birthday) 78 Yrs.	Months Days	Hours Min.	5/8/19	y, Year) C	ountry)
9	Director		220-26-3387 Usual Residence of Decedent		70			7/0/13	THI.	IDAND
	yland		10a. State 10b. County	1	10c. City, Town or Le	ocation				10d. Inside City Limits
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	or 28	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	ountry?
	23a	Funeral Director	1306 GLENMONT	· · · · · · · · · · · · · · · · · · ·		212	-		USA	
	tems	nue	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (Si an, Mexican, Puert	pecify Yes or No Dican, etc.)	14. Race - Am Black, Wh	
36	rs afte	by F	1 ☐ Never Married 2 🛣 Mai 3 ☐ Widowed 4 ☐ Divorce	I Yes Give	S. WITT	1 ☐ Yes 2 ☐XNo	Specify:		Specify:	WHITE
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212		Completed	Elementary/Secondary (0-12)	9 YEARS	SCH	OOL PRING	CIPAL		SCHOOLS	
	be filed ital Hygie id other	Bec	17. Father's Name (First, Middle,	, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surname)	
/lai	should be t nd Mental I marked o umatic eve	10 10	CLARENCE WILI	LIAMS			1	S DROST		
Maryland	d 2 should th and Men 7 is marks traumatic		19a. Informant's Name/Relation	ship (Type, Print)	19b. Maili	ing Address (Street			er, City or Town, State,	Zip Code)
	an eath		LORRAINE WILL	CAMS/WIFE	20b. Place of Disp	GLENMON'	road T	OWSON, N	MD 21239 20c. Location - City o	r Town State
9	0 0 = 5		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 Removal from Sta	te cemetery, cre	matory`or other pla				
ţ	tmen tant:		4 Donation 5 Other (		METRO CRI	•			CATONSVIL	
Baltimore,	permit. Pag Department important: i any injury o		21. Signature of Funeral Service	Licensee			RAVEN BL		ON FUNERAL	286
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a	1/		30. Name and address of perso	n who completed cause of	of death (ftem 23a) (Type				-/1/0	0
1	) " 1	-	Joseph A. F	Idams M.D.	6701 N.	Charles	St. #1	1104 1	maltimore.	mo 21204
	St	ate	31. Date filed (Month, Day, Yea	1)200C 38 Reg	istrar's Signature	<u> </u>		1-1-2-1/ P	7	
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State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Robert Howard Wiedefeld, Sr. 10:35 p February 3, 2006 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Columbia **Brighton Gardens Assisted Living** Howard If Under 1 Year | If Under 24 Hrs. Sex 1M 2□ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Director 82 213.12.0686 February 13, 1923 Maryland Usual Residence of Decedent 10a. State 10b, Count 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Howard West Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21794 2709 Friendship Farm Court U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Ves 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 ☐ Widowed 4 ☐ Divorced White "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) Housing & Urban Construction analyst Development 12 Pages 1 and 2 should be filed vent of Health and Mental Hygie int: If Item 27 Is marked other? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be J. Howard Wiedefeld Helen Schenkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2709 Friendship Farm Court West Friendship, Maryland 21794 Ms. Marie Wiedefeld Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) 02/07/2006 Clarksville, Maryland St. Louis Cemetery 21. Sigratu/e of Fune al Service MO1293 22. Name and Address of Facility Slack Funeral Home, P.A 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Supper /Medical Due to (or as a conseque Examiner CREBRUKAS carles Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Degenerative Dementra The law requires that the death certificate be executed attending physicien and for use as the burial-transit P.O. Box 68760, LYPEITEN SION Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 Yes 1 ☐ Yes 2 ☐ No 2 No To the Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA 5 Residence 6 ☐Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of cartifier 29c. License numbe 29d. Date signed (Month, Day, Year) February 6, 2006 D22856 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Levine, Jerry I. MD 11055 Little Patuxent Parkway, Suite 104 Columbia, MD 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** WELCH LEE SANDRA February 10, 2006 18586W /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montsomery

9. Birthplace (State or Foreign Country) <u>Shady Grove Hospital</u> Rockville 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Nov. 19 **Funeral** Year) Days 1 M & XXF Months Hours Min. 48 230-76-2857 Director DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2☐No Director Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6630 Coldstream Drive 21774 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2XXMarried 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stewart Lee Payne Carolyn 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aaron Welch Husband 6630 Coldstream Drive New Market MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State South Carroll Crematory Feb. 13, 2006 Winfield, MD 4 Donation 5 Other (Specify) ure of Funeral Service Licens e 22. Name and Address of Facility Burrier-Oueen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 ANT ALIM 23a. Par 1. Enter be disease, or complications that caused the dishock or heat failure. List only one cause on each line. th. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Caus (Fi al disease or condition resulting in death) Physician SEPSL いてきに /Medical Due to (or as a consequence of): Examiner OUNLAN CANCER MEMSATIC if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner siclen and e burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical the attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1. Inpatient Certification: To 2 ER/Outpatrent 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 Yes 2 No investigation M 2 Accident tor 9 6 Could not be 3 Suicide hours after de uneral Directo 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) à 4 Homicide lilled in Hospital within 24 hours a 12 Certifying Physician: To the best of my knowledge death oncurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Chack only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) FEB 1 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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UMOL YTAZ

32. Registrar's Signature

ORIGINAL

20057954

FEBRUARY (Z, 2006

CM JULY MD

			1 - For Stete Registrer	State of Maryla		artment of F		nd Mental Hy	2006	01.178
	*		Decedent's Name (First, Middle, Last	·			Dodin	2. Date of D	Regúlio U U	3. Time of Death
	Physici		Clara Zapalowi	C.7				Feb.	Day Ye	ar 106 5:50 p <sup>M</sup>
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or	r Location of		4c. County of D	
	LXamii	C.	Future Care Ca		r		imore		n/	
	Funeral		5. Social Security Number 6. Se	x 7. Age (In y	rs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of B		Birthplace (State or Foreign
	Director		213-09-5271	M 2 <b>/2</b> 5F	37 Yrs.	Months Days	Hours	Min. (Month, E	18 M	(Sountry)
	p ,		Usual Residence of Decedent  10a. State 10b. County	100	City Town and					
	anyla shov	2			City, Town or Lo					10d. Inside City Limits 1    Yes 2   No
	Ba-f	Director	Md n/a		Baltim					
	with the sor 2 ke n	Dir	10e. Street and Number			10f. Zip Code	0.7		10g. Citizen of What	Country?
	s 23s	ra	359 Folcroft S		- 11.0	212		10 (C	USA	American Indian.
	ter de Item	Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No	10.5.	f Yes, specify Cuba	an, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)		White, etc.
36	hours after death with the Maryland turel', or Items 23a or 28a-f show at Execution from the profitted at	by F	3 Widowed 4 □ Divorced	If Yes, Give		1 ☐ Yes 2 🗷 No	Specify:		Specify:	White
21215-0036	J within 72 hours after death with the Marylan jiene. r than "natural", or Items 23a or 28a-f show Ite Medical Estandiae mast ke nolliked at	ted	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occup	ation		16b. Kind of Busine	
215	within 7, ene. than "n	pie	(Specify only highest grad Elementary/Secondary (0-12)	le completed) College (1-4or 5+)	(Give	kind of work done on DO NOT use retired	during most d)	of working		
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b	be filed ntal Hygin od other event, I	Be (	17. Father's Name (First, Middle, Last)				18. Mother	's Name (First, Middl	e, Maiden Surname)	
<u> a</u>	should be nd Mental marked c	To	Frank Szumlan	ski			Jos	sephine A	Antczak	
Maryland	2 shoul and Me is mari		19a. Informant's Name/Relationship (T	vpe, Print)					ber, City or Town, Stai	
	Ð € N ₽		Theodore R. Zap	alowicz					imore, M	
Baltimore,	of Heal of Heal if Item 2		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ I	Removal from State	<ul> <li>Place of Dispo cemetery, crer</li> </ul>	sition (Name of natory or other plac	ce)	Date	20c. Location - City	or Town, State
Ë	permit. Pages Department of I Important: If Its any injury or or once.		`4 ☐ Donation 5 ☐ Other (Specify,			nislaus		2/17/06	Baltimo	
at	permit. Departr Importa any inju		21. Signature of Funeral Service Licens	01			es de Ficility	Funeral 1	Home P.A.	
	80 5 5 9		Cugere y	(and						Md. 21222
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caused the di ne cause on each line.	eath. Do not ent	er the mode of dyin	ng, such as o	cardiac or respiratory	arrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. · · A	SCVI	()				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a cons	sequence of):	C D	0/ -			
	Cxammer	_	Sequentially list conditions,	b. Arr	iAL	FBri	LL AT	00		
7	sit sit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	sequence of,	1 Ell try				
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8760,	death certificate be executed e attending physicien and of for use as the burial-transit	E E		Due to (or as a cons	sequence or).					
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Вох	atten for u	ian	in the past 12 months?	1☐Live birth 2☐F 4☐Pregnant at time of	etal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of Month	Day Year
Ö	the de	ysic	1 Yes 2 Vo 9 Unknown	9☐ Unknown	or death of					
ص	law requires that the de as been signed by the a 2 should be detached		Part II. Other significant conditions co	ntributing to death but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did	tobacco use contribut	e to the cause of death?
ds	uires signe	d by	DOTED A	WHITS,	UT	I		10	Yes 2 3 3	Probably 4 Unknown
COL	v require been sig should b	iete						24a. Wa	s an 24h Were	autopsy findings available
Records,	9 -	Completed						aut	opsy formed? prior deat	to completion of cause of
Vital	ician: Th certificate rector, pag	e Cc	25. Was case referred to medical				OG Disease	1 Yes		Yes 20 No
S	Physician: this certific	o B	examiner?	Hospital: 1 ☐ Inpatient 2	ER/Outpatien	nt 3□ DOA Oth		of Death (Check only	sidence 6 Other (\$	Procifu)
o	Phys or this oral di	E,	27. Manner of Death	28a. Date of Injury	28b. Time of				how injury occurred	эрөспу)
on	tending leath. tor: After the funer	ţ	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury		k? Yes 2∐N	lo		
Division	Attending r death. ector: After by the fune	ifice	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A		eet, factory, office			(Street and Number o	r Rural Route Number,
Ö	al or	Certification:	4   Homicide	building, etc. (Spe	өспу)			City of 10	ów⊓, State)	
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only 2 Medical Exam	rsician: To the best of my liner: On the basis of exam	knowledge, death	occurred at the tin	ne, date and	place, and due to the	e cause(s) and manne	r as stated.
	in 24 in 24 in Fi	edicai	one)	and manner stated.	uriation and/or in	vestigation, in my o	pinion, deat	n occurred at the time		
	To To To To To To To To To To To To To T	Σ	29b. Signature and vitle of certifier			29c. Licens		_ /	29d. Date signed (M	
•				W		O,	242	.76	2. 13.	26
	1.		30. Name and address of person who co	ompleted cause of death (I	1.3			A 0		
	Co		2001 H	w) fr 55		1 Must	n	w 2	1724	
	Sta Registr		31. Date filed (Moeth Day, Year), 20	06 32 legistrar's Si	gnature	ach a				
	negisti	aı		Jan Barre	AS PAR					

			1 - For State Registrar	State of M	laryland / Dep	artment of Health ar rtificate of Death	nd Mental Hygie	2006	04179
	Physici	an.	1. Decedent's Name (First, Middle,				Date of Death     Month	Day Year	3. Time of Death
	/Media		Wilda	Mae	Avey			5, 2006	6:00 A. M
	Examir	ner	4a. Facility Name (If not institution,	give street and number,	)	4b. City, Town, or Location of D	Death	4c. County of Death	
			Memorial Hospit 5. Social Security Number		al Center ge (In yrs. last birthday,	Cumberlar		Allegany	place (State of Francisco
	Funeral Director		236-62-5579 Usual Residence of Decedent	- Class of Chr.	65 Yrs.		A CONTRACTOR OF MARKET	1940	place (State or Foreign
	Maryland I-f ehow	tor	10a. State 10b. County Alleg	any	10c. City, Town or L Cum	perland			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	with the 3a or 28a	Il Direc	10e. Street and Number  9 East Roberts S	Street		10f. Zip Code 21502	10g	. Citizen of What Cou	intry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertments if term 27 is marked other then "natural", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Examinal must be notified at ance.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F	1? (Specify Yes or No- Puerto Rican, etc.)	14. Race - Amer Black, White Specify: Whi	, etc.
21215-0036	hin 72 ho s. en "natur Medical	pleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Give	dent's Usual Occupation a kind of work done during most of DO NOT use retired)	f working	b. Kind of Business/I	•
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n d	2 should be filed withir and Mental Hygiene. Is marked other then aumatic event, the Mis	To Be (	17. Father's Name (First, Middle, L Marion Brelsfo				Name (First, Middle, Mai ah (Kerns) B	,	
Mary	nd 2 shot lith and N 27 is ma		19a. Informant's Name/Relationshi William Avey	o (Type, Print) husb	oand 19b. Mail	ing Address (Street and Number of ast Roberts Stree	or Rural Route Number, Cet Cumbe	City or Town, State, Zi	21502
Baltimore,	ages 1 and 2 int of Health t: if item 27 i		20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe		20b. Place of Disp cemetery, cre Restlawn M	osition (Name of matory or other place) lemorial Gardens		c. Location - City or T	own, State
Baltir	permit. Pag Depertment Important: I eny injury o		21. Signature of Funeral Service Li			<sup>2. Nam</sup> Sand Addins F Lacilly 108 Virginia Ave	Il Home, PA	T-1.	
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or of shock, of heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as		ter the mode of dying, such as ca	rdiac or respiratory arrest	t,	Approximate Interval Between Onset and Death
8760, <	ate be executed hysicien and the burial-transit	ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequence of):				
P.O. Box 68	The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)		23d. Date of delik	rery Day Year
ds, ห	uires that n signed b id be deta	5	Part II. Other significant condition	s contributing to death	but not resulting in the i	underlying cause given in Part I.		cco use contribute to	the cause of death?
Records,	e iav	Completed					24a. Was an autopsy performe	prior to or death?	opsy findings available ompletion of cause of
		BeC	25. Was case referred to medical			26. Place of	1 ☐ Yes 2 ☐ f Death (Check only one)	3,140 TI TES	2 140
<b>&gt;</b>	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 🙀 Inpati	ient 2 ER/Outpatie	Othor	ing Home 5 ☐ Residence	ce 6 Other (Spec	fy)
	After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		ay Year) 28b. Time (		28d. Describe how		
Division	s after de el Directo	Certific	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	ed 286. Place of in	njury - At home, farm, si tc. <i>(Specify)</i>	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	al Route Number,
	To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification;	29a. Certifier 1  Certifying (Check only one)	Physician: To the best caminer: On the basis and manner s	of examination and/or in	th occurred at the time, date and provestigation, in my opinion, death	place, and due to the caus occurred at the time, date	se(s) and manner as and place, and due	stated. to the cause(s)
	To the comp	M	29b. Signature and title of centries	2		29c. License number		I. Date signed (Month	
	1.		30. Name and address of person w	V		•	re	ebruary <sup>G</sup> ,	2006
	P		Suril Gupta	N.D. 625	Kent Aven	ue Suitelol	Cumberlane	1 Maryla	nd 21502
	Sta Registi		31. Date filed (Month, Day, Year)	32. Regist	trar's Signature	AV		•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 4, **Physician** 2006 11:25 AM Edna Virginia Albaugh /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Northampton Manor Health Care Center Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State Months | Days | Hours | Min. | July 16, 1916 | Maryland 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 217-10-0212 1 ☐ M 2 🗓 F 89 Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 28e-f show the Medical Examiner must be notified at Frederick Maryland Frederick 1 Yes XXNo Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a or 8328-B Walter Martz Road 21702 U.S.A. death v Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White þ 3X Widowed 4 ☐ Divorced 'natural', Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72. Deperment of Health and Mental Hygiene. Important: if Item 27 is marked other then "na eny injury or other treumatic event. The Medic once. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur E. Hoffmaster Maude Zimmerman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. Nicholas Albaugh, Jr., son 8524 Walter Martz Road, Frederick, MD 21702 20a. Method of Disposition
XXX Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Mount Olivet Cemetery Feb. 8, 2006 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens e 22 Keeney and Basford PA Funeral Home M00255 106 East Church St., Frederick, MD 23a. Part1. Enter the disease, or complications that deused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** for colposition of the colpositi 7 Dows 5 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physicien Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant ed by the attended for u 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 3 Probably 4 Unknown pertenson Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No —— 24a. Was an has autopsy performed 1 Tes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation s effer dea. 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral C completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 6, 2006

DHMH 17 Rev 1/2001

State

Registrar

homos

FEB 1 4 2006

31. Date filed (Month, Day, Year)

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1. Decedent's Name (First,

4a. Facility Name (If not ins

Heritage Har 5. Social Security Number

244-05-6701

Frances Ba

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larbou	ır Health&	Rehab. Cente	er Annap	olis		Anne	Arun	del	
mber	6. Sex	7. Age (In yrs. last birth	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	place (State o	r Foreigi
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Decedent									
10b. Count	у	10c. City, Town of	r Location					10d. fnside Cit	y Limits
Anne	Arundel	Anr	apolis					1 🗆 Yes	2 <b>XX</b> \0

**Funeral** Director

Physician

/Medical

Examiner

Usual Residence of Deced 10a. State b Maryland An

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland Deperment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f ahow any injury or other traumatic avent, the Madical Examiner must be publised at once.

Physician /Medical Examiner

within 24 hours efter death. To the Funeral Director; Alter this certificate hes been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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To Be Completed by Funeral Direct	10e. Street and Number			10f. Zip Coo	le	1	log. Citizen of What Co	ountry?
<u>a</u>	2908 Southwater P	oint Drive			21401		USA	
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T <sub>0</sub>	Jessie Bateman				Mary	Bateman		
	19a. Informant's Name/Relationship (7		1				r, City or Town, State,	
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Completed by Physician/Medical Examiner	Part II. Other significant conditions co	ontributing to death but not resi	ulting in the	underlying cause	given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
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Mec	29b. Signature and title of certifier	and manner stated.	-	29¢ Lie	ense number		9d Date signed /Mog	th Day Year!

29c. License number

29d. Date signed (Month, Day, Year)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 3 0 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Oscar Farias 1667 Crofton Medical Center Crofton, Maryland 21114

Registrar's Signature

			1 - For State Registrar	State of I	Maryla			t of H	ealth a				006	04182
	Physici	ian	Decedent's Name (First, Middle, Last)								2. Date of D	eath		3. Time of Death
	/Medi		James Gibson	Beard							Februa	ary 3	, 2006	7:56 A.M
	Examir	ner	4a. Facility Name (If not institution, give s	treet and numb	er)				Location o	of Death			County of De	
	F		318 Roberts Way  5. Social Security Number 6. Sex	7	A00 /In um	s. last birthday)	Abe If Under	erdee	If Under:	24 Hea		1	arford	
	Funeral Director			M 2□F	63	Yrs.	Months	Days	Hours	Min.	8. Date of Bi (Month, D 3/11/1	1942 1942	9. B Ma	irthplace (State or Foreign Country) ryland
	filed within 72 hours after death with the Maryland Hygiene. ther then "natural", or itams 23a or 28e-f show ant, it a Medical Exeminar i ust be notified at		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
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	or 28	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What (	Country?
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	and sealth m 27		Jeanette C. Davis	(Friend		318	Rober	ts W	<i>l</i> ay		deen,			21001
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from Sta	20b.	Place of Dispo cemetery, crer	sition (Nam	e of her place	)	D	ate	20c. Lo	cation - City o	r Town, State
<u>=</u>	nit. Pag eartment ortent: injury e		* 4 ☐ Donation 5 ☐ Dther (Specify)	Mausole					1	2/7/0	)6	Aber	deen. 1	Maryland
Baltimore,	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service License	302	lmo	22	Name and Tarri Aberd	Address ng-C	of Eacilib		ral H			
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1	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  completely filled in by the funeral director, page 2 should be detached for use as the buriat-transit	edical	(Check only 2 Medical Examine one)	er: On the basis and manner s		ation and/or inv	estigation, in	n my opi	nion, death	1 Occurre	d at the time,	date and	place, and du	e to the cause(s)
-	withi To the	Σ	29b. Signature and title of certifier				29c.	License	number			29d. Date	signed (Mon	th, Day, Year)
			DIL 1	17			1	D31	1052			Fob.	MUNU	3 1006
5	*1		30. Name and address of person who com	pleted cause of	death (Item		rint)	R	110	11.	Ma.	× 14.	1 2	3 LOOG
	Stat	e	31. Date filed (Month, Day, Year)	32. Regis	trar's Signa						, ,,,	1 1070	14	' U' /

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Day Year Feb. 2006 LILLIAN BOWERS 6, ABIGAIL /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 900 LaGrange Road Street Harford If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 8/23/1915 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 20 F 217-14-2364 90 Director Yrs. Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28a-f show the Medical Executive triust be notified at 1 Yes 2 No MD. Harford Street Direct 10e. Street and Number 10f Zip Code 10g, Citizen of What Country? 21154 900 LaGrange Road United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Housewife Home and Mental Hygi or other treumetic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be innert of Health and Mental is interest of the street of the s Ora Corbett Mary Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rowland A. Bowers /Son 910 LaGrange Rd. Street, Maryland 21154 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Importent: If any injury or once. Fork Meth. Cem. 2/8/2006 ' 4 ☐ Donation 5 ☐ Other (Specify) Fork, Maryland 21. Signature of Funeral Service/Ligensee 22. Name and Address of Facility Jarrettsville, Maryland E.G. Kurtz & Son Funeral Home, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEPATIC FAILURG **Physician** /Medical Due to (or as a consequence of): **Examiner** CHOLANGIO CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. igned by the attending physician be detached for use as the buria Completed by Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 MNo 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Cther (specify) 9 Unknown 9 Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? TYPE II DIABETES 1 Yes 2 No 3 Probably 4 Unknown been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☑ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending NA 1 Yes 2 No investigation 2 Accident completely filled in by the Director 6 Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 1 4 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SERENA R. NOLAN, MD

Noten us

00025010

8831 SATYR HILL RD SUITE 100 PARKVILLE, MD 21234

February 7, 2006

			- For	State of Maryland / Depart	artment of Health and		iene	01.181.
		1	State Registrar	Ce	rtificate of Death		eg. No.	04104
	Physicia	_	Decedent's Name (First, Middle, Last)			2. Date of Deat Month	Day Year	3. Time of Death
	/Medic	al -		BAKER	4. Ch. T	FEBRUA	RY 8 2006 4c. County of Death	
	Examin	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Location of De Marydel	eatn	Caroli	
	Francis		27140 Marydel R  5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 H			place (State or Foreign intry)
	Funeral Director			M 2√ F 64 Yrs.	Months Days Hours M	Feb 11	1941 Mar	yland
7	D >		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	neation			10d. Inside City Limits
	shov	5	MD Caroli					1 ☐ Yes 2 ☑ No
	the M	Director	10e. Street and Number	ne haryu	10f. Zip Code	1	0g. Citizen of What Co	intry?
	Mith Sa or		27140 Marydel	Rd.	21649		U.S.A.	
	be filed within 72 hours after death with the Maryland hal Hygiene. And under then 'natural', or items 23s or 28s-f show event, the Madical Examitrer mast be natified at	Funeral			Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu	(Specify Yes or No-	14. Race - Amer Black, White	
က္က .	or Ite		1 ☐ Never Married 2 🔀 Married	1 ☐ Yes 2 ☑ No If Yes, Give	1 Yes 2 No Specify:	iono moun, oto.,		White
21215-0036	ural;	d by	3 Widowed 4 Divorced	Year or Dates:			16b. Kind of Business/l	
7	n 72 • nat	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Give	dent's Usual Occupation kind of work done during most of t DO NOT use retired)	working	TOD. KING OF COSTITESSY	noustry
12	with iene.	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	ormation Proce	essor	Bank	
ğ	a filed I Hyg other ent,	BeC	17. Father's Name (First, Middle, Last)		18. Mother's N	Name (First, Middle, I	Maiden Surname)	
<u> a</u>	uid be Venta irked itic ev	To B	Roy Kenneth Kl			el Britta		
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Proportment of Health and Mental Hygiene. I have free 21s marked other then "natural", or items 21s are reserved other then "natural", or items 21s are real any injury or other traumatic event, free Madical Examinating the natified at once.		19a. Informant's Name/Relationship (Typ		ng Address <i>(Street and Number</i> or 240 Marydel Ro			
<u>ء</u> ف	l and lealth sm 27 sm 27 sher tu		Ernest Don Bake: 20a. Method of Disposition	20b. Place of Dispo	-	-	20c. Location - City or	
Baltimore,	ages nt of h		1 ☐ Burial 2 🔯 Cremation 3 🗆 R	emoval from State cemetery, cre	matory or other place)	/9/06	Smyrna,	
를	nit. Pa artme ortant injury		'4 □ Donation 5 □ Other (Specify)  21. Signature of Fig. ral Service License		2 Name and Address of Facility		-	
Ba	Deparim Important it any it		1	G:	alena Funeral 18 West Cross	Home of	Stephen	L Schaech
			23a. Part 1. Enter the disease, or complications, or heart failure. List only on	cations that caused the deeth. Do not en	ter the mode of dying, such as card	diac or respiratory arm	est,	Approximate Interval Between
	nysician:		Immediate Cause (Final disease or condition	PARCLEATIC	CARCINOMA	•		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				30307-216
	Examine	Ļ	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence of):				
	ted nsit	nine	Cause (Disease or injury	Due to (or as a consequence or).				
	te be executed ysician and te burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a consequence of):				
760,	ate be executed nysician and he burial-transit	cail						
	ntifical ng ph		IF FEMALE:					
Вох	The law requires that the death certifica te has been signed by the attending ph page 2 should be detached for use as th	by Physician/Med	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy		23d. Date of deli Month	very Day Year
o.	the a	ysic	1 ☐ Yes 2 Z No 9 ☐ Unknown	4☐Pregnant at time of death 5   9☐Unknown	Other (specify)			
٣.	that [f	Ph/		ntributing to death but not resulting in the	underlying cause given in Part I.	23e. Did to	bacco use contribute to	the cause of death?
Vital Records,	uires 1 sign 1d be					1 U Y	es 2. No 3 □ Pr	obably 4 Unknown
00	w requir s been si should	Completed				24a. Was a	an 24b. Were au	topsy findings available completion of cause of
æ	The lav	mo				— autops perfor 1 ☐ Yes	med2 death? 2 No 1 ☐ Yes	2 No
	10	Be C	25. Was case referred to medical examiner?			Death (Check only or	ne)	
of <	Physicien: this certific ral director,	일	1 ☐ Yes 2 ☐ No	lospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie			ence 6 Other (Spec	cify)
	ding P	i o	27. Manner of Death 1 ☑ Natural 5 ☑ Pending	28a. Date of Injury (Month, Day Year) 28b. Time (Injury)	of 28c. Injury at Work?  M 1 ☐ Yes 2 ☐ No	28d. Describe h	ow injury occurred	
isio	Attending r death. sctor: After oy the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s		28f. Location (S	itreet and Number or Ru	ıral Route Number,
	or Attendated after death Director:	Certification:	4 ☐ Homicide determined	building, etc. (Specify)	and a start of the	City or Tow	n, State)	
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director After this certific completely filled in by the funeral director.			sician: To the best of my knowledge, dea				
	he Ho in 24 ihe Fu	edical	one)	ner: On the basis of examination and/or in and manner stated.				
	To the within 2. To the I complete	Σ	29b. Signature and title of certifier		29c. License number		29d. Date signed (Monti	n, Day, Year)
,			106	and the second of the second o	D0060	1201	010100	
	12		30. Name and address of person who co	mer. M.D. 122	speer Rd. Che	stertown	, MD. 216	520
	Sta	ate	31. Date-filed (Month, Day, Year)	32. Registrar's Signature				
	Regist	rar	FEB 1 4 2006	Corner 1st frill	"			

		For State Registrar	State of Mar	ylanc		artment of H		and Me		iene	06	04185
Physici	an	1. Decedent's Name (First, Middle, L.		11.	,			2	. Date of Dear Month	th Day	Year	3. Time of Death
/Medic	al	4a. Facility Name (If not institution, gi		tle	7	4b. City, Town, o	r Location o	of Dooth	Jan	29	2006 nty of Death	12:44 PM
Examin	er	University of Mus	y land Mediz	cal C	Leuter	~ //	ore	or Ceau		40.000	UM	
Funeral Director		Ol Wilder 21.	1		st birthday) Yrs.	If Under 1 Year Months Days	If Under : Hours	Min.	Date of Birth (Month, Day)	Year)	9. Birthr Cour Geor	place (State or Foreign ntry) <b>gia</b>
and		Usual Residence of Decedent  10a. State 10b. County	1	10c. City,	Town or Lo	cation					1	Od. Inside City Limits
Maryl -f sho	tor	Maryland Freder	ick	Free	derick	•						1 <b>x</b> Yes 2 □ No
death with the Maryland ims 23a or 28a-f show ir must be notified at	Funeral Directo	10e. Street and Number 1317 Peartree C	ourt			10f. Zip Code 21703			1	0g. Citizen o	of What Cour	ntry?
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2 hou satura		15. Decedent's E	Education		16a. Deced	lent's Usual Occup	ation			16b. Kind of	Business/In	dustry
ithin 7	Completed	(Specify only highest gi	College (1-4or 5+)		life. l	kind of work done o DO NOT use retired .esman	during most	or working		A11+	omobil	۵
Hygier ther th		17. Father's Name (First, Middle, Las	<u>Z</u>		Sal	esman	18. Mothe	r's Name (/	First, Middle, i			
IZITICI lid be fill fental H rked oth	То Ве	Melton Le		tley				tty		ansley		
Taryla 2 should and Men is marke sumatic		19a. Informant's Name/Relationship	(Type, Print)			g Address (Street				-		Code)
e, IV		Dinah Bentley/Wi	fe	20h Pla		Peartree		t, Fre				Num Clain
ages land of H		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 [ 4 □ Donation 5 □ Other (Spec				sition (Name of natory or other place					n - City or To	
Dallinofe, permit. Pages 1 and Department of Healt important; if item 2 any injury or other once.		21. Signature of Puneral Service Lice		St.	22	Cemetery  Name and Address	ss of Facilit		ffer Fu	ıneral		, PA
		23a Party Enter the disease or dor	nolications that caused th	ne death		.621 Opos					k, MD	Z1/UZ Approximate
Physician /Medical		23a. Part Part the disease, or dor shock, or heart failure. List out Immediate Cause (Final disease or condition resulting in death)	a. Ancxic	Br	ain	Injury	g, 30011 23		ospiratory an	931,		Interval Between Onset and Death
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₽ ≅	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	conseque	ence of):			10				
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rtificat		IE EENALE.				721	NONED B					
OI VILGI NECOLOS, R.O. BOX 00100, Physician: The law requires that the death certificate be executed this certificate hes been signed by the attending physicien and ral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal	death 3□	Ectopic pregnancy Other (specify)					Date of delive Month	ery Day Year
wrequires that been signed by should be detail	þ	Part II. Other significant conditions	contnbuting to death but	not result	ting in the ur	nderlying cause give	en in Part I.		23e. Did tol	1/		ne cause of death?
aw requir	Completed								24a. Was a	n 24	b. Were auto	psy findings available mpletion of cause of
VICAL DE INCIENT THE INCIENT T	mo:								autops perform	ned? 2 No	death?	mpletion of cause of 2□ No
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Physi Physi rahis o	: To	1 X Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient		R/Outpatien		4 🗀 140		5 Reside			y)
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urs eff			office	Bini	Iding -	- ATM		100				edirk, MD
DIVISION OF LIGHT REPORT OF VICE INC. To the Hospital or Attending Physician: The I within 24 bours elide death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	edical	29a. Certifier 12 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of each and manner state	xamınatio id.	on and/or inv	estigation, in my o	pinion, dear	th occurred	at the time, d	ate and plac	e, and due to	the cause(s)
To the To the Complex	Me	29b. Signature and little of certifier			>	29c. Licens	e number	7	2	9d. Date sign	ned (Month,	Day, Year) 2006 4D 21201
AVIN		30. Name and address of person who	Completed cause of dea	th (Item	23a) (Tyna	1/19 Print)	/1/			JUN	71	2006
DK C.		Translaw Moder	e/ 22	Sou	th C	eene St.	Sui	te si	4007	Bult	more, 1	4D 21201
Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Phistrar's	s Signatu	ire							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Patricia 11:55P<sup>M</sup> January 23, 2006 Burke /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Center Prince George's Laurel 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) Funeral: Days Hours 1 ☐ M 2 🖾 F Yrs. Director 70 578-46-9116 1935 Wash. D.C March 7. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "netural", or Itams 23a or 28a-f ehow The Medical Examiner must be multiled at 1 XYes 2 No Maryland Prince George's Lanham Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8802 Groton Court 20706 United States Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Black þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Business Manager Verizon or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill iment of Health and Mental H tant: If item 27 is marked other. Ralph W. Alexander, Sr. Carolyn Harris Alexander 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9927 Marquerita Ave., Susan Anderson (Sister) Glenn Dale, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 1/27/2006 4 Donation 5 Other (Specify) Beltsville, MD. J 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee re Mon 7400 Georgia Ave., N.W., Washington, D.C. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cancer of the pancreas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that iniliated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physicien and s the burial-translt Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy signed by the atte Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ General Debility 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hypertension has performed? Yes 2X No 2**X** No 1 Tyes 1 Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical funeral director 26. Place of Death (Check only one) Hospital: Other: 4 🖔 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) Certification: To 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident the 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 | Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D45217 January 30, 2006 30. Name and address of person who mpleted cape of death (Item 23a) (Type, Print) 10 6201 Greenbelt Road, Adebowale Ajay**(** M.D. College Park, MD. 20740 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006

Registrar

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Esther Catherine Boyer January 28, 2006 4:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rockville Nursing Home Rockville Montgomery 8. Date of Birth (Month, Day, Year) Country)
April 29, 1910 Washington, DC If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F 577-40-3596 95Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County Worde ! r then "neturel", or iteme 23e or 28e-f ehov the Medical Expromer must be notified at 1 Yes 2 No Directo Maryland Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20814 10661 Weymouth Street, #102 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Elementary/Secondary (0-12) College (1-4or 5+) 12 Communication Pages 1 and 2 should be filed withment of Health and Mental Hygier tant: If Item 27 is marked other theury or other treumatic event, List Supervisor Army Medical Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Rowley Katherine Venable ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10661 Weymouth Street, #102, Bethesda, MD 20814 Brian Boyer/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 0 = 0 January 1 ☐ Burial 2 XX remation 3 ☐ Removal from State Department of important: If eny injury or once. Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 2006 F<sup>22</sup>d Mread Address Cblowns Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 21. Signature of Juneral Service Licensee Killard I 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Atheroscleratio resulting in death) /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner death certificate be executed ed by the attending physician and detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Day Month Year 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 ☐ Unknown signed by Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 🗌 Yes 2 X10 3 ☐ Probably 4 ☐ Unknown Completed peeu 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b director, page 2 s autopsy performe 2 No 1 ☐ Yes 2X No or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 1 Tes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3□ DOA Director: After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation M 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours e To the Funeral ( To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier icai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier atticia 30 Name and address of person who completed cause of death (Item Kville Pike, G-100, Rockville, 10ms ricia Vac 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

			1- State of Maryland / Dep	artment of Health and artificate of Death	, 0	2006	01.188
			Decedent's Name (First, Middle, Last)	Tunodio or Dodin	Reg.  2. Date of Death		3. Time of Death
	Physici /Medio		George E. Cook, Jr.		January	26 2006	7:55 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	7.33
			Pleasant View Nursing Home	Mount Airy		Carrol1	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	) If Under 1 Year If Under 24 Hrs Months Days Hours Min.		9. Birthy	place (State or Foreign
	Director		215-32-5353 G9 Yrs. Usual Residence of Decedent		Nov. 2, 1	.936 Mar	yĺand
	ow i		10a. State 10b. County 10c. City, Town or L	ocation		1	I Od. Inside City Limits
	Many Firsh	to	Maryland Carroll Moun	t Airy			1 ☐ Yes 2 ☒ No
	r 28s	Directo	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cour	ntry?
	th wit		1313 Ellis Road	21771		United Sta	ates
	ems ems	Funeral		Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puen		14. Race - Americ Black, White,	can Indian,
36	72 hours after death with the Maryland natural; or items 23a or 28a-f show Jisal Extra ref must be notified at	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No	1 ☐ Yes 2 ☒ No Specify:			ack.
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212	filed within Hygiene. Ithar than "	шо	Elementary/Secondary (0-12) College (1-4or 5+)	rick Layer		Construc	ction
Þ	e filec Il Hyg otha vent,	BeC	17. Father's Name (First, Middle, Last)		me (First, Middle, Maid		
Maryland 2121	should be nd Mental s marked o umatic eve	To E	George E. Cook, Sr.	Helen	Johnson		
an	2 should be filed within 72 hours after death with the Marylan and Mend thygiens the with the marked of thy than "natural", or items 23a or 28a-f show aumatic event, the Mucical Examinational by notified at	·	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Ru	ural Route Number, Ci	ty or Town, State, Zip	Code)
	is 1 and 2 should of Health and Men Itam 27 is marke other traumatic		Sheila Jackson / Daughter 18542	Eagle's Roost Dr			
O.			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of Disposition cemetery, cre	osition (Name of matory or other place)	uarv 2.	. Location - City or To	
Baltimore,	tant:					. Airy, Ma	
Ba	permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	2. Name and Address of Facility St E. Ridgeville Bly	auffer Fun vd. Mt. Ai	eral Homes iry, Maryl	s, P.A. and 21771
			23a. Part1. Enter the disease or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Priysician		Immediate Cause (Final disease or condition 1498EGTEUS/VE	CARDIOVASCU			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				/
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ХOЯ	eath certifi attending   for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 [	DEctopic pregnancy		23d. Date of delive	ory
о П	e dea he ati	sicia	1 Yes 2 No	Other (specify)		Month	Day Year
<del>ب</del>	d by the deletached	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	-4-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-	OD- Didah		
S D	The law requires that the death cert te has been signed by the attending bage 2 should be detached for use a	l by	RECURRENT CENEBRA VASO	nderlying cause given in Part I.  **ENMN ACCIONG**	239. Did tobacc	co use contribute to th	
Ö	w require been si should b	Completed			177111		
Ę	elaw hast	mpl			24a. Was an autopsy performed	24b. Were autor prior to cor death?	psy findings available apletion of cause of
Vital Records,			OF Warrange design		1□ Yes 2⊡		2 No
5	sicial certii recto	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	0.1	ath (Check only one)		V-1
Ö	a Phy ar this aral d	$\vdash \parallel$	27. Manner of Death 28a. Date of Injury 28b. Time of		lome 5 Residence 28d. Describe how in		′)
<u> </u>	ath. T: Afte	atloi	1 ☑ Natural 5 ☐ Pending (Month, Day Year) Injury 2 ☐ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
DIVISION	r Atte	ertiflcation;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street City or Town, St.	and Number or Rura	l Route Number,
5	talor rs aft ral Dii	O	Salarity, otal (Specify)		01.9 01 101111, 52.	210)	
	To the Hospital or Attending Physician: within 24 hours after death within 24 hours after death of the Funaral Director. After this certifical completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  1	n occurred at the time, date and place vestigation, in my opinion, death occu	, and due to the cause rred at the time, date a	e(s) and manner as stand place, and due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	29c. License number	29d. l	Date signed (Month, I	Day, Year)
			> Mellell - h.	D. D26499	9	1-27-	06
	h		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
			Ronald E. Miller, M.D. 4 Culwell Dr	rive Mt. Airy, Ma	ryland 217	71	
	Sta Registra	te ar	31. Date filed (Month Cay, Year) 32. Figistrar's Signature	(			

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2006 2:10 P M February 3, Mary Louise Davis /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Crofton Crofton Convalescent Center Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** Hours Days 1 M 2(XF 3-19-1916 Washington, DC Director 577-10-2560 89 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or itema 23e or 28e-f show any injury or other traumatic avent, the Medical Examinat must be notified at 10a. State 10b. County 1 ☐ Yes 2 No Edgewater Directo Maryland Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21037 USA 860 Holly Ave. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status Black White etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify Specify: þ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 8th Beauty Parlor Beautician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Sarah W. Moroney Bozzi Francesco 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 860 Holly Ave., Edgewater, MD 21037 Carla D. Paddy/ Niece 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-9-06 Suitland, MD Cedar Hill Cemetery 4 ☐ Donation 5 ☐ Other (Specify) vice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pulmonary Obstryctive Disease **Physician** Chronic /Medical Due to (or as a consequence of): Examiner 1-enosis nonar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner Nascular Distan The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown been signed be should be deta 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 4 Dunknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? hes 1 ☐ Yes 2 ☐ No certificate 1 Yes 2 No director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 3 DOA this 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Medical Certification: 5 Pending investigation Division or Attending Injury 1 Naturat 1 Yes 2 No within 24 hours after death.

To the Funaral Diractor: A completely filled in by the fu 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town. State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 110/191 D2010 MD OIKE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rakesh Arora, M.D. 14300 Gallant Fox Ln. Bowie, MD 20715 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 4 2006 Registrar

ORIGINAL

			1 - For State Registrar	State of Maryland /		artment of H rtificate of I			iene () () () eg. No.	04190
	Physici /Medio		Decedent's Name (First, Middle, Last)     Eleanor		isma	ın		2. Date of Dear Month January	Day Ye	3. Time of Death 5PM M
	Examir		4a. Facility Name (If not institution, give to Calvert County		er		Location of Death Frederi	ck	4c. County of E	
	Funeral Director	1100	5. Social Security Number 6. Set 171–28–5182  Usual Residence of Decedent	7. Age (In yrs. last)	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 28	<sup>year)</sup> 1914 Pe	Birthplace (State or Foreign Country) nnsylvania
	Maryland -f ehow	tor	10a. State Maryland Calvert	10c. City, To	own or Lo	rederick				10d. Inside City Limits
	th with the 23s or 28s	Funeral Director	10e. Street and Number 85 Hospital Road			10f. Zip Code 206	78	1	Og. Citizen of Wha	
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other then "naturat", or Iteme 23a or 28a-f ehow event, I're Medical Exemplat must be neitlied at	by		12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ (X)No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 1 No	ispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. hite
Maryland 21215-0036	d within 72 ho piene. r then "natur I're Medical.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done of DO NOT use retired Clerk	ation during most of worki f)	ing	16b. Kind of Busin	
and ?	S E S	Be	17. Father's Name (First, Middle, Last) Steven L. Bowers				18. Mother's Name	Shoop	Maiden Surname)	
Maryl	s 1 and 2 should it Health and Men Item 27 le marke other traumatic.	오	19a. Informant's Name/Relationship (Ty Judith Ann Brown-	pe, Print) 19 daughter 47	9b. Mailir 70 We	ng Address (Street est Dares	and Number or Rura	al Route Number	; City or Town, Sta	te, Zip Code) 20678 E Frederick MD
Baltimore,	Pages 1 an nent of Heal out: If Item 2 ury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place ceme	tery, crer	esition (Name of matory or other place Funeral Se			20c. Location - City	
Balti	permit. Pages Department of Importent: If it eny injury or o		21. Signature of Funeral Service License		22	2. Name and Addres	4 F I'm.	usch Funer	al Home	,
*	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or hearf failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do no cause on each line.  SEPSIS  Due to (or as a consequence).  PERIPHER	o not ent	er the mode of dyin	g, such as cardiac (	or respiratory arre	est,	Approximate Interval Between Onset and Death DAYS
68760,	icate be executed physicien and s the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence	e of):	VIII	CCARC	DIS EAS		
P.O. Box 68	ath certif	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ➡ No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 □Live birth 2 □ Fetal dea 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
	n requires that the de been signed by the s should be detached f	by	Part II. Dther significant conditions cor	ntributing to death but not resulting	in the u	nderlying cause give	en in Part I.			te to the cause of death?  Probably 4 2 nknown
al Reco		Completed						24a. Was a autops perform	y prior ned2 deat	e autopsy findings available to completion of cause of h? Yes 2 \sum No
	Phyeicien: Th r this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{No} \) \( \text{No} \)	lospital: 1  Inpatient 2 ER/0	Dutpatien	it 3□ DOA Othi	26. Place of Death er: 4 Nursing Ho		e) ance 6 Other (	Specify)
Division of Vital Records,	ding h. After fune	Certification:	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day Year)  28b. Place of Injury - At home,	Time of Injury	M 1	y at k? Yes 2 □ No	28d. Describe ho	ow injury occurred	or Rural Route Number.
2	spitel or ours efte teret Dir filled in		4 Homicide determined  29a. Certifier 1 Certifying Phys	building, etc. (Specify) sician: To the best of my knowled	ge, deat!	n occurred at the tin	ne, date and place,	City or Town	n, State)	or as stated.
	To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 ☐ Medical Examile one) 2 ☐ Medical Examile of certifier	ner: On the basis of examination a and manner stated.	and/or inv	vestigation, in my o	pinion, death occurr	ed at the time, d	ate and place, and 9d. Date signed (N	due to the cause(s)
)	F S F Ö		1 Peter 7	m mo			0370		1/30/0	
	4		30. Name and address of person who co Peter Wisienski MD 10	mpleted cause of death (Item 23a O Hospital Rd. Prin	(Type, ER	Print) ederick MD	20678			
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registra's Signature	K	Sperker				

**ORIGINAL** 

			For State Registrar	State of Ma	aryland /	-		nt of Ho ete of E		-	giene Reg. No	UUO	04192
*	Physici /Medic		1. Decedent's Name (First, Middle, Las Marjorie Ann Fi	η Ltts						2. Date of De. Month Janua:	Da	y Year 88, 2006	3. Time of Death 10:45 A M
	Examir Funeral Director	.55	4a. Facility Name (If not institution, give Genesis Eldercare 5. Social Security Number 6. So 002-20-3086	- Layhill	Cente: (In yrs. last t			Silve er 1 Year	r Spring If Under 24 Hrs Hours Min.	9	th.	Montgome 9. Birth Cor 1927 Mas	
	D		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Lo	cation						10d. Inside City Limits
	e Ma	ctor	Maryland Montgo	mery	Sil	ver	Spr	ing					1 Yes 2 No
	th with th	al Director	10e. Street and Number 11809 Goodloe Roa	đ				ip Code 20906			10g. Cit	tizen of What Cou USA	untry?
036	be filed within 72 hours after death with the Maryland ital Hygiene. d other than "natural", or items 23e or 28e-f show event, I're Medical Exertinal must be mullisd at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent B Armed Forces? 1 💆 Yes 2 🗌 N If Yes, Give Year or Dates: 3	lo	*	f Yes, sp	edent of His ecify Cubar 2  No	spanic Origin? (S , Mexican, Puer Specify:	pecify Yes or No o Rican, etc.)		14. Race - Amer Black, White SpecifyWhit	, etc.
Maryland 21215-0036	within 72 ho ene. than "natur ne Medical I	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12			(Give . life. [	kind of v	ual Occupa vork done di use retired)	tion uring most of wo	rking		aind of Business/I	,
and 2	m - 0 =	Be	17. Father's Name (First, Middle, Last)  Joseph Eck						18. Mother's Nar Sarah	ne <i>(First, Middl</i> e, Henlv			
2	should nd Me mark	To	19a. Informant's Name/Relationship (7	ype, Print)	19	9b. Mailin	ng Addre	ss (Street a			er, City o	or Town, State, Z	ip Code)
	and 2 salth a n 27 id		Karen L. Ray/ Dau	ghter		1180	)9 G	odloe	Road,	Silver S	pri	ng, MD 2	0906
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If tea 27 is marked any Injury or other traumatic as DDGs.		20a. Method of Disposition  1. □ Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify	)	20b. Place cemet Gate o			ame of other place Cemeter				ocation - City or 1 rer Sprin	Town, State ng, Maryland
Ball	permit Depart Import any in		21. Signature of Funeral Service Licen	wen of	)	F <del>2</del>	dire 0 Ur	nivers	ල්රැ¶ins sity Blv	Funeral d, W, Si	Hor 1ve	me Inc r Spring	, MD 20901
*	Physician /Medical Examiner		23a. Part1. Enter the disease, or companies, or heart failure. List only disease or condition resulting in death)	elications that caused one cause on each line.  a. Pneumor.  Due to (or as a chronic	nia a consequenc	e of):				c or respiratory au	rrest,		Approximate Interval Batween Onset and Death Day Years
68/60,	ificate be executed g physicien and as the buriat-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c									
C. Box	death certif e ettending d for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal deal		Ectopic Other (	pregnancy specify)	-			23d. Date of deliver Month	very Day Year
rds, r	es tha gned be de	þ	Part II. Other significant conditions co	ontributing to death bu	ut not resulting	in the ur	ndertying	cause give	n in Part I.	\$			the cause of death?
al Kecord	The law ate has b page 2 st	Completed								24a. Was autop perfo 1 Yes	sy rmed?	prior to o death?	opsy findings available ompletion of cause of
VII	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	nt 2 ER/C	D. 42 - 4		04-		th (Check only o			
lon of	ding PI n. After th funeral	atlon: To	27. Manner of Death  1 🖾 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injur (Month, Day	y 28b	Time of Injury	M	28c. Injury Work	4 EZHIVUI SING F	28d. Describe h		6 Other (Specify occurred	( <b>!y</b> )
DIVISION	tal or Attent's after deatlal Director:	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding. etc	ry - At home, :. (Specily)	farm, stre	eet, facto	ery, office		28f. Location (S City or Tov	Street ar vn, State	nd Number or Ru e)	ral Route Number,
	the Hospital or hin 24 hours afte the Funeral Dire npletely filled in h	edicai	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best of iner: On the basis of and manner sta	examination a	ge, death and/or inv	occurre estigation	d at the time on, in my opi	a, date and place nion, death occu	, and due to the tred at the time,	cause(s date and	) and manner as d place, and due	stated. to the cause(s)
	To the To the Complete	Σ	29b. Signature and titte of certifier	Du	rel	1	UD	9c. License D38	number 262			ite signed (Month January	30, 2006
1.	+1		30. Name and address of person who of Dr. Anurita Mend	hiratta	2401 R			Blvd,	#330,	Rockvill	e, N	MD 20850	
1	Sta Registr	te ar	31. Date filed (Month Pay Year) 3 1	32. <b>Be</b> gistra	r's Signature	A	meth						

			Please	Type or Pri					-		•	
			1 - For State Registrar	State of M	aryland		artment of rtificate o	f Health and I of Death	Mental Hy	giene Reg. No.	006	14193
		ex.	Decedent's Name (First, Middle, La	ast)					2. Date of De			3. Time of Death
	Physici /Medio		Phyllis Ann	F	leisch	er			Janua	ry 2	6, 2006	4:15 p M
2,5	Examir		4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Tow	n, or Location of Deat	h	4c.	County of Death	
1			15101 Interlach	en Drive,	#807		Silve	er Spring			Mor	ntgomery
) J =	Funeral Director		5. Social Security Number 6. 270-10-3414	Sex 7. Ag	e (In yrs. ia 90		If Under 1 Ye Months Da		8. Date of Bi (Month, D March 2	th av Year	9. Birthp Cour Ohi	place (State or Foreign htry)
	9		Usual Residence of Decedent									
	rylar		10a. State 10b. County			Town or Lo					1	Od. Inside City Limits
	e Ma	cto	Maryland Montg	omery	Si	lver	Spring					1 ☐ Yes 2 No
	th with th	Funeral Director	10e. Street and Number 15101 Interlacher	Drive, #8	307		10f. Zip Cod 209			10g. Citiz	ven of What Cour USA	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "netural", or Iteme 23a or 28a-f show eny Injury or other traumatic event, I'm Medical Examinat manal by notified.	þ	11. Marital Status  1 Never Married 2 Marned 3 Never Married 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 Yes, Give Year or Dates:			Was Decedent of the second of	of Hispanic Origin? (S buban, Mexican, Puerl No Specify:	Specify Yes or Note Rican, etc.)		4. Race - Americ Black, White, Specify: Whit	etc.
2-0	72 ho	ted	15. Decedent's E (Specify only highest gi			16a. Dece	dent's Usual Oc	cupation ne during most of wo	duna	16b. Kir	nd of Business/In	dustry
2121	ywithin 7 jiene. r then "r	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	Cle	DO NOT use re	rired)	rking	U.S.	. Govern	ment
Maryland 21215-0036	12 should be filed within hand Mental Hygiene. 7 is marked other then "traumatic event, the Mes	To Be C	17. Father's Name (First, Middle, Las Samuel Zarzour	")				18. Mother's Nar Anna	me (First, Middle Slilaty		Sumame)	
	and 2 shores alth and N n 27 is ma		19a. Informant's Name/Relationship James M. Fleisch				-	oet and Number or Ru Olney Lar				
Baltimore,	Pages 1 and nent of Hesint: If Item		20a. Method of Disposition  1 Burial 2 Cremation 3 4 Donation 5 Other (Spec		cer	metery, cre	osition (Name of matory or other even Cemet	place) Febr	ruary 1,		cation - City or To	own, State
Balti	permit. Departm Imports eny Inju		21. Signature of Funeral Service Lice	onsee Que		5	2. Name and Ad rancis 00 Univ	dess of Facility J. Collins ersity Bly	Funera	l Hor	me Inc r Spring	, MD 20901
	Physician /Medical Examiner		23a. Part1. Exter the disease, or cor shock, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each li	c Obs	truct		dying, such as cardiad		arrest,		Approximate Interval Between Onset and Death
68760,	ate be executed whysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as  c. Due to (or as  d.	· · · · · · · · · · · · · · · · · · ·							
.O. Box 6	at the death certificate be ex by the attending physician tached for use as the buria	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal o	death 3[	□Ectopic pregna □ Other (specify			2	23d. Date of delive Month	ery Day Year
9	es tha gned be de		Part II. Other significant conditions Arteriosclerotic					given in Part I.				ne cause of death?
0	w requir been si should	etec		041410141	, - u - u -				1.2	103 2		Jabiy 4 Dollkilowii
I Records,	The la ate has page 2	Completed by							24a. Was auto perf 1 \( \text{Yes}	omed?	prior to co death?	psy findings available impletion of cause of 2 No
Vital	iclan: Th certificate rector, pag	Be	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only	one)		
of V	Physiclan: this certific al director,	10	1 Yes 2 No	Hospital: 1   Inpati	ent 2 E	P/Outpatie	nt 3 DOA	Other: 4   Nursing H	lome 5 Res	idence 6	Other (Specif	y)
o uoi	ding h. After fune		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigate	28a. Date of Inju (Month, Da	y Year)	28b. Time o Injury		niury at Work? □ Yes 2 □ No	28d. Describe	how injury	occurred .	
Division	P di i	Certification:	3 Suicide 6 Could not 4 Homicide determined	286. Place of in	jury - At hon ic. (Specify)	ne, farm, st	reet, factory, offi	Ce		(Street and own, State)	d Number or Rura	il Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medicai (	29a. Certifier 1 Certifying P (Check only 2 Medical Exe	hysicien: To the best miner: On the basis of and manner st	of examination	rledge, deat on and/or in	h occurred at th	e time, date and place ny opinion, death occu	e, and due to the urred at the time	cause(s) , date and	and manner as s place, and due to	tated. o the cause(s)
	To the within 2 To the complet	Z	29b. Signature and title of certifier	1	40		29c. Lic	ense number D08381			signed (Month, January	Day, Year) 27, 2006

State Registrar 31. Date filed (Month, Pay, Year) 32. AN 3 1 2006

32. Aggistrar's Signature

30. Name and address of person who completed cause of death (Hem 23a) (Type Brint) Prive, Olney, MD 20832 Benjamin (Avrunin, M.D. 4669 Cherry Valley Drive, Olney, MD 20832

			For State Registrar		State of M	arylan		artment of F		and M	ental Hy	giene Reg. No.	006	04/94
	Dhusisi		1. Decedent's Name	(First, Middle, La.	st)						2. Date of D Month	eath Day	Year	3. Time of Death
	Physici /Medic				Gribben						Jan 3	1 2006	6	10:30A M
	Examin	er			e street and number)			4b. City, Town, o		of Death			County of Dea	th
			5. Social Security Nu		7 46	o /le ure	last birthday)	St. Leon		24 Hrs	0. Data of B		lvert	
	Funeral Director		212–34–6021		M 2□ F	69 69	Yrs.	Months Days	Hours	Min.	8. Date of Bi (Month, D	ay, Year)	Co	thplace (State or Foreign ountry)
			Usual Residence of D								July 14	1936	Mary	Land
	anylan show	Ļ	Maryland	10b. County  Calvert			y, Town or Lo							10d. Inside City Limits
	Ba-f	Director												1 ☐ Yes 2 No
	with the		10e. Street and Number 6021 Linder					10f. Zip Code 20685					en of What Co	•
	leath	era	11. Marital Status	11 KOAU	12. Was Decedent	Ever in U	S. 13 1		lispanic Orig	nin? (Sne	cify Yes or N		4. Race - Ame	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than *natural*, or items 23e or 28e-f show the Wedical Examinat count be rediffed at	by Funeral	1 Never Marrier 3 Widowed 4		Armed Forces?  1  Yes 2  If Yes, Give Year or Dates:	•	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2√2 No	Specify:	, Puerto F	Rican, etc.)		Black, Whit	e, etc.
Ş	72 hor	Completed	(Specific	15. Decedent's Ed	ducation		16a. Dece	dent's Usual Occup	ation			16b. Kin	d of Business	/Industry
7	i within 72 ho liene. r than *natu	nple	Elementary/Secon-	y onfy highest gra dary (0-12)	College (1-4or	5+)	life.	kind of work done of DO NOT use retired	auring mosi d)	t of workin	ng			
7	e filed wi al Hygien other th vent, the	Con	12		2		procum	rent specia				B.G.		
שב	Δ 22 To e	Be	17. Father's Name (F		)						(First, Middle	e, Maiden S	Sumame)	
Ĕ	should ind Men ind Men ind marke	욘	Foward Gri		Tuna Print)		10b Mailie	ng Address (Street	Laura			has Cityas	Town Chain	Tie Codel
S	id 2 sho Ith and 27 is mu		Shirley A.					inden Rd. S				-	Town, State, I	ZIP Code)
<u>ი</u>	s 1 and 2 shou of Health and M Item 27 is mar other traumati		20a. Method of Dispo		WELC	20b. F	Nace of Diago	aiting (Mana of					cation - City or	Town, State
Ē	9 2 2		1 🔀 Burial 2 🗆 1 4 □ Donation 5		]Removal from State v)	st.	John Via	natory or other place conney Cemeto	**) Feb ery	4 200	)6	Prince	Frederi	ck Maryland
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Fun	eral Service Licer	1500		22	2. Name and Addres	ss of Facilit		h Funer	al Hom	e	
			23a, Part1, Enter the	disease, or com	plications that caused	d the deat	h Do not ent	5 Broomes	Is. Rd	. Port	People I	ic M.	20676	Approximate
			shock, or heart Immediate Cause (F	failure. List only	one cause on each li	ne.		· ·	-					Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		a Due to (or as		IAC	AF		•				2 123.
	Examiner						+ RY	ART	ERY		Dise	- ASE	=	12 years
	1	Jer	Sequentially list conditioning to immoduse. Enter Underly Cause (Disease or in	ditions, nediate	Due to (or as	a conseq	uence of):		1					. 0
	cuted nd ransit	Examin	that initiated events		C									
Š	e exe ian a urial-t		resulting in death) La	ast	Due to (or as	a conseq	uence of):							
8/6U	icate be executed physician and s the burial-transit	dical			d									
×	ding page as	/Me	IF FEMALE:		23c If yes outcome	of progn	2004							
O. Box	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent print the past 12 mm 1 Yes 2 19 Unknown	nonths?	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Feta	Ideath 3	Ectopic pregnancy Other (specify)	′			23	3d. Date of de Month	livery Day Year
Į.	that the by deta	y Ph	Part II. Other signific	ant conditions of	contributing to death b	out not res	ulting in the u	nderlying cause giv	en in Part I.		23e. Did	tobacco us	se contribute to	the cause of death?
ecords,	equires en sign suld be	ed by	1. CONC	ES71 V	E HE	AR	T	FAILU	RE		1 🗆	Yes 2	No 3□P	robably 4 🗀 Unknown
င္ပ	law requas been 2 shouk	Completed	2 Exog	enous	06	بنده	Ty.				24a. Wa	s an opsy	24b. Were au	utopsy findings available completion of cause of
r		Com	3 (	Slee	p A	pn	ea				perf	ormed?	death?	2 No
VItal	ysician: Th is certificate director, pag	Be (	25. Was case referre	d to medical	-					of Death	(Check only	one)		
0	hysi this c	P	1 ☐ Yes 2 N	lo	Hospital: 1 Inpatie		ER/Outpatien		4 1140	rsing Hom	1000		□Other (Spe	cify)
Division	or Attending Physafter death. Director: After this in by the funeral di	atlon:	27. Manner of Death  Natural  Compared Accident	5 Pending investigation		iry ly Year)	28b. Time of Injury	Wor	yat k? Yes 2⊡!		.8d. Describe	how injury	occurred	
<u> </u>	tai or Att rs after d af Direct ed in by t	Certification:	3  Suicide 4  Homicide	6 Could not b determined		ury - At ho	ome, farm, str y)	eet, factory, office		2	28f. Location City or To	(Street and own, State)	Number or Ri	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier 1 (Check only 2 one)	Certifying Ph	nysician: To the best niner: On the basis of and manner st	it examina	wledge, death	n occurred at the tin vestigation, in my o	ne, date an pinion, deal	d place, a th occurre	and due to the	cause(s) a , date and p	and manner as place, and due	s stated. s to the cause(s)
	with To 1	Σ	29b. Signature and ti	itle of certifier  YUVA  A	M. D.	Rysia	iin	29c. Licens	e number	27		29d. Date	signed (Mont	th, Day, Year)
	15+1		A T Munsh	i MD Prino	completed cause of c	death (Iten	n 23a) (Type, and 2067	Print)		•				
	Sta Registr	_	31. Date filed (Month	FEB -	1 2006	as Signa	iture							
DH	MH 17 Rev 1/2					CRECAS	1 15	Mount						

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State of Registrar		artment of Health and rtificate of Death	Mental Hygie	UUU	04195
			Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physicia		Viola Mary Gi	bson	٠		30 2006	5:45 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and nu		4b. City, Town, or Location of Dear		4c. County of Deat	
			5010 Lee Hill Circle		Monrovia		Freder	ick
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birt	hplace (State or Foreign untry)
	Director		195-16-1627 <sup>1□M 2⊠F</sup>	81 Yrs.		Jan. 4, 1	925 Peni	nsýlvania
	and ₩		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	daryli f sho	ō	Maryland Frederick	Monrov				1 ☐ Yes 2 ☒ No
	28e-	Directo	10e. Street and Number	Montov	10f. Zip Code	100	Citizen of What Co	untry?
	as or		5010 Lee Hill Circle		21770		United St	•
	ms 2;	Funerai	11. Marital Status 12. Was Dec	edent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (\$ If Yes, specify Cuban, Mexican, Puer		14. Race - Ame	
ယ	or Ital		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes	2 🔼 No		to Rican, etc.)	Black, White	
ğ	rsl', c	by	3 ☑ Widowed 4 ☐ Divorced If Yes, Gi Year or D		1 ☐ Yes 2 ☒ No Specify:		Specify:	White
S P	within 72 hours after death with the Maryland ene. Then "natural", or Itams 23a or 28e-f show fre Medical Exercinal must be mallised at	Completed	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupation kind of work done during most of wo	nkina 16b	Kind of Business/	Industry
7	ithin and and and and and and and and and an	ηpi	Elementary/Secondary (0-12) College (	1-4or 5+) life.	DO NOT use retired)			
72	led w lygier her ti		12	I	Head Cashier		Grocery S	tore
anc	be fi	Be	17. Father's Name (First, Middle, Last)			me (First, Middle, Maid		
Ž	hould d Me nark netic	To	Francis J. Portzer  19a. Informant's Name/Relationship (Type, Print)	10h Maille	Mary ng Address (Street and Number or R	C. Johnst		F- 0- 4-1
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department: If item 27 is marked other than "naturst; or Itams 23a or 28e-f show morprant: If item 27 is marked other than "naturst; or Itams are not in the mast be putilised at once.		Cary Gibson / son		Riverside Avenue			
စ်	1 an Heal tem 2		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		Location - City or	
Baltimore,	ages ant of t: If if		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from 1 ☐ Donation 5 ☐ Other (Specify)	State	reb	ruary 1		
量	nit. Fartme ortar injur e.		21. Sign ture of Tureral Service Licensee	Frederick	Crematory St	2006 Fre	derick,	Maryland
ä	Depa Impo eny ir		14/17	8	E. Ridgeville Bl	vd. Mr. A	erai nome irv. Marv	s, r.A. land 21771
			23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on					Approximate
	Physician		Immediate Cause (Final	JACTI IIINE.				Interval Between Onset and Death
	/Medical		disease or condition resulting in death) a. Due to	(or as a consequence of):				
	Examiner		Sequentially list conditions, b.	O4D				
	י פ	iner	f any, leading to immediate cause. Enter Underlying Cause (Disease or injury	(or as a consequence of):				
	acute ind trans	Examiner	that initiated events c.					
8760,	cate be executed bhysician and the burial-transit	Ē	Due to	(or as a consequence of):				
87	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	dicai	d					MARK IN ST.
9 ×	ding	/Me	IF FEMALE: 23c If yes ou	tcome of pregnancy			001.0	
Вох	atten for us	ian	in the past 12 months?	oirth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
o.	that the death certifed by the attending detached for use as	Physician/M	1 ☐ Yes 2 📆 No 9 ☐ Unknown 9 ☐ Unkn		Cities (specify)			
<u>α</u>	that ned b	by Pr	Part II. Other significant conditions contributing to d	eath but not resulting in the u	ndertying cause given in Part I.	23e. Did tobaco	o use contribute to	the cause of death?
Vital Records,	quires to signeral lid be	d b				1 ☐ Yes	2 □ No 3 □ Pro	obably 4 Unknown
CO	s been s	Completed				24a. Was an	24b. Were au	topsy findings available
Re	The law te has age 2 s	шо				autopsy performed	prior to death?	completion of cause of
ta		0	25. Was case referred to medical		26. Place of De	1 ☐ Yes 2 🔀 ath (Check only one)	40 11 163	2 140
	Physicien: this certific	To B	examiner? 1 Tes 2 No Hospital: 1	Inpatient 2 ER/Outpatien	Othor	lome 5 Residence	6 ☐ Other (Spec	city)
0	ter th		27. Manner of Death 28a. Date  Natural 5 ☐ Pending (Mon	of Injury 28b. Time of Injury	28c. Injury at Work?	28d. Describe how in	jury occurred	
Sio	Attending r death. sctor: After by the fune	atic	2 Accident investigation		M 1 Yes 2 No			
Division of	after d Direct Jin by 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 28e. Place build	of Injury - At home, farm, str ing, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer							
	e Hospitel 24 hours a e Funerel letely filled	edicai	(Check only 2 Medical Examiner: On the	a best of my knowledge, death asis of examination and/or in- ner stated.	n occurred at the time, date and place vestigation, in my opinion, death occ	e, and due to the cause urred at the time, date :	(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	- Contract	_29c. License number	29d.	Date signed (Month	i, Qay, Year)
)	⊢≯⊢ŏ		O LOOK	my )	1)5290	6	1/27	12/0
	10		39 Name and address of person who completed cau	se of death (Item 23a) (Type	Print)		11 50	1 4
	10		DR. Jill Dunt	ee 610		2170	3	
	⇒ Sta	te	31. Date filed (Month, Day, Year) 32. F					
9	Registr	ar	FEB 0 1 2006	Down St ,	grove			

			1 - For State Registrar	State of M	laryland	-	artment of H tificate of I			giene Reg. No. 0 0 6	04	196
22	- A.	7.	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea	ath	3.	Time of Death
	Physici /Medic		Gerald	Edward	l	Hora	in		January			1:00 a M
-	Examin	er	4a. Facility Name (If not institution, give				- 1	Location of Death		4c. County of		
24 <sub>0</sub> 0	Funeral		Calvert Memorial  5. Social Security Number 6. S		ge (In yrs. la	ast birthday)	Prince I If Under 1 Year	Frederick  If Under 24 Hrs.	8. Date of Birt	Calve		(State or Foreign
	Director			<b>™</b> 2□ F	64	Yrs.	Months Days	Hours Min.	June 2	1, 1941	Country)	ylvania
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation				10d le	nside City Limits
	Maryla	jo	MD Calver	t	1.00.0.0.0	, 101111 01 20	Hunting	town				☐Yes 2XNo
	r 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citizen ol Wh	at Country?	
	23a o	ai D	4110 Old Town Roa	d			2063	9		USA		
	er dea	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?		Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Dican, etc.)		American In White, etc.	idian,
38	filed within 72 hours after death with the Maryland Hygiene. vther then "naturel", or Iteme 23a or 28a-f ehow ent, Ite Medical Evarither med by notified at	by F	1 ☐ Never Married 2 🌠 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🔀 If Yes, Give Year or Dates:			1 ☐ Yes 2X No	Specify:		Specify:	white	
2-003	72 hou	ted	15. Decedent's Ed (Specify only highest gra			16a. Dece	ient's Usual Occup	ation	kina	16b. Kind of Busi		
2121	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	DO NDT use retired	1)	ang			
22	illed w rlygier ther ti nt, m	Col	17. Father's Name (First, Middle, Last)	4		buil	ding con		A (First Middle	CONS	tructi	on
Maryland	d ta b	To Be	Ouintin		Horan			Grace	Miner			
ary	S D E E	-	19a. Informant's Name/Relationship (			19b. Mailir	g Address (Street	and Number or Ru	ral Route Numbe	r, City or Town, St	ate, Zip Code	9)
	5 5 5 E		Bonnie S. Horan,	wife			Old Town				20639	
ore	Pages 1 ar		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	Ce	metery, crer	sition (Name of natory or other place	:e)	Date	20c. Location - Ci		
altimore,	- 돈만든		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fungral Service Licer		Che		ke Highla . Name and Addres		3-2006	Port Re	public	
Ba	Depa Impo eny ii		1 William	R. Cre	مر		ausch Fu		ne, P.A.	, Owings	, MD 2	0736
ф. 19	,		23a. Part1. Enter the disease, or com- shock, or heart lailure. List only	plications that cause one cause on each	d the death. line.	. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Inte	roximate rval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a. (his	NL 0	bitive	the prim	way d	fe-81		Ons	set and Death
	/Medical Examiner		resulting in dealin)	Due to (or as	a consequ	ence of):	•	/			,	
		ler	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	s a conseque	ence ol):				<del></del>		
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
, 20	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as	a conseque	ence ol):						
58760	physics the t	edicai	•	d								
Box	The law requires that the death certificate has been signed by the attending plage 2 should be detached for use as to	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			DE -4 - : :			23d. Date	of delivery	
_	e deatl	Physician/M	in the past 12 months? 1 🗆 Yes 2 🗆 No	1□Live birth 4□Pregnant a 9□Unknown			Ectopic pregnancy Other (specify)			Month	n Day	Year
J.	n requires that the de been signed by the should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions c		but not resul	Iting in the w	derhing cause and	on in Part I	23e Did to	bacco use contrib	ute to the car	use of death?
ds,	uires t signe Id be c	d by	m 17.7-2-1 0	tual to	بالريد		idenying cause give	sirsir acci.	1 🖳			4 Unknown
Ö	s beer shou	iete			1	`			24a. Was a		ore autopsy fi	ndings available
Ä	sicien: The law s certificate has t irector, page 2 s	Completed								med? prid	or to complet ath? ]Yes 2∐	ion of cause of
<u>E</u>		Bec	25. Was case referred to medical examiner?					26. Place of Dear				
5	Physi this c	유	1 Yes 2 No	Hospital: 1 pati		R/Outpatien		4   Nursing n		ence 6 Other		
0	ding P th. After t funera	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	28b. Time ol Injury	28c. Injury Work	Yes 2 □ No	28d. Describe n	ow injury occurred	1	
Division of Vital Records,	Attender dear	Certification:	3 Suicide 6 Could not be determined	28e. Place ol In	jury - At hor tc. (Specify)	me, larm, str	eet, lactory, office		281. Location (S City or Tow	Street and Number	or Rural Rou	ite Number,
ā	ital or rrs afte ral Dir lled in											
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funaral Director: After this certifics completely filled in by the funeral director.	Medicai	29a. Certifier 1 V Certifying Ph	ysician: To the best ner: On the basis of and manner s	ot examination	vledge, death on and/or inv	occurred at the time restigation, in my of	ne, date and place, pinion, death occur	and due to the or red at the time, or	cause(s) and mann date and place, and	er as stated. d due to the	cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier				29c. License	a number	i	29d. Date signed (	Month, Day,	Year)
)			Ilm ly				DUL	314		1/21/0	6	
	15		30. Name and address of person who			23a) (Type,	0 1	310 G	and To	duch, M	0 00	478
	Sta Registr		31. Date filed (Month, Day, Year)	32. Regist	ras Signatu	ure M	South 8	V		1111	- 20	V (V
6-4	19 to		OMMIN	T FOOD	THE REAL	-	A CONTRACTOR OF THE PARTY OF TH					

			1 - State Registrar	State of	Maryla			nt of H		Mental Hy	/giene		6	04197
	Physici /Medj		1. Decedent's Name (First, Middle, Las Elsie Mae Haus	<i>t</i> )				_		2. Date of D Month	eath Da	y	Year	3. Time of Death 3:43PM
•	Examir		4a. Facility Name (If not institution, give Doctors Community				4b. Cit	y, Town, or Lanhai	Location of Dea		40	. County	of Death	orge's
	Funeral Director		188-05-3558	9X □ M 2[X]F		. last birthday) 89 Yrs.	If Und Month	er 1 Year S Days	If Under 24 Hr Hours Mir		irth 197, 197	6	9. Birthp Cour Penn	place (State or Foreign ntry) Sylvania
	with the Maryland a or 28a-f show Libe notified at	ctor	Usual Residence of Decedent  10a. State  Maryland  Prince G	eorge's		ity. Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 X No
	th with the 23a or 2	Funeral Director	10e. Street and Number 4416 Tonquil Plac	e			10f. 2	ip Code 207	705			tizen of W nited		
7/C 036	ours after death reif, or items 23.	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Drvorced	12. Was Deced Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? ⊠No		If Yes, sp	edent of Hi ecify Cuba 2X No	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-		c, White,	can Indian, etc. nite
$S/c$ $\mathcal{M}$ and 21215-0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "netural; or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinat near be notified at once.	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de <i>completed)</i> Coll <b>ege</b> (1-4	lor 5+)	life.	kind of v	rork done d use retired	turing most of w	orking	16b. K	(ind of Bus	hom	,
7/2 and	d be filed antal Hyg sed othe c event,	Be	17. Father's Name (First, Middle, Last)  Isaac	T <sub>o</sub>	leaver				18. Mother's Na	ime (First, Middle	e, Maider	Sumame		
Maryl	12 shoul h and Me 7 is mark raumati	2	19a. Informant's Name/Relationship (7	уре, Print)		19b. Mailir			and Number or F	Rural Route Numi		or Town, S	State, Zip	Code)
A.S.	iges 1 and nt of Health if Itam 27 or other to		Sharon E. Sealock  20a. Method of Disposition  1X Burial 2 Cremation 3	Removal from St	20b.	Place of Dispo cemetery, cres	sition (N	ame of other plac	e)	lumbia,	20c. L	ocation - (	City or To	044 own, State
Haus Baltimore	permit. Pa Departmer Important eny injury once.		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen:		الحالم الم					/30/2000 t Funera			•	land 20705
	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aSep	SiS as a conse	th. Do not ent	er the mo	ode of dyin	g, such as cardiá	ac or respiratory	arrest,			Approximate Interval Between Onset and Death
- 1		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a conse		-							
8760,	icate be executed physician and s the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or	ere Ai	quence of):								
9	entificate ling phys e as the	Medicai	IF FEMALE:		0 1									
.O. Bo)	that the death certific ed by the attending p detached for use as I	by Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ØNo 9 ☐ Unknown	23c. If yes, outco 1□Live birt 4□Pregnar 9□Unknow	h 2∐Feta ntattime of	aldeath 3[	Ectopic Other (	pregnancy specify)				23d. Date Mon		ery Day Year
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	To the To the Complex	W	29b. Signature and title of certifier	M	1	b	2	D31				ite signed lary		2006
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			1 - For State Registrar	State of M	laryland	•	rtmen <i>tificat</i>			ınd <b>M</b> ei		giene Reg. No. 0	16	04198
П	Physici		Decedent's Name (First, Middle, Las Berta Herna:								Date of Dea Month Januar	Day	006	3. Time of Death 2:50 p M
4	/Medio Examir		4a. Fecility Name (If not institution, give Mariner Health Ca			ıng	-		Location o			4c. County		
22	- Funeral Director		377 30 0132	x 7. A	ge (In yrs. Ia 92	st birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. Ma	Date of Birt (Month, Day ay 20,	y. Year) 1913	Cou	place (State or Foreign ntry) atemala
	sa-f show	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Montgot	mery	,	Town or Lo	prin							10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	h with th		10e. Street and Number 8712 Geren Road				10f. Zip	Code 901				10g. Citizen of V US		ntry?
9036	d within 72 hours after death with the Maryland liene. I than "natural", or Itema 23a or 28a-1 show The Madical Examiriar must be notilled at	d by Funerai	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces 1 ☐ Yes 2 M If Yes, Give Year or Dates:	?	1	Yes, spe	cify Cubar	n, Mexican	gin? (Specif , Puerto Ric Guaten		Blad	e - Amenick, White, White	
Maryland 21215-0036	iene. r then	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12) 12	cation le completed) College (1-4or	5+)		lent's Usu kind of wo DO NOT u maket	rk done d se retired)	tion u <i>ring</i> most	of working		16b. Kind of B	usiness/In n Hor	
/land	s 1 and 2 should be filled if Health and Mental Hygis Item 27 is marked other other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Francisco Hernane	lez						r's Name (F ne Gar		Maiden Suman	пе)	
Man	and 2 shou ealth and M n 27 is mar er traumat		19a. Informant's Name/Relationship (7 Oscar Carcamo/ son									er, City or Town, urch, V		
ore,			20a. Method of Disposition 1 🖂 Surial 2 Cremation 3 🗆	Removal from State	cer	ce of Dispo netery, cren of Hea	sition (Nai natory or c	ne of other place		Date	9	20c. Location -	City or To	
Baltimore,	permit. Page Department Important: If any injury or once.		4 □ Donation 5 □ Other (Specify  21. Signature of Juneral Service License  **The August Land Land Land Land Land Land Land Land		Gate	$\mathbf{F}^{22}$	Name ar	d Addres	cofficient	ins Fu	neral	Home I	nc	MD 20901
1 to 1 to 1 to 1 to 1 to 1 to 1 to 1 to	Physician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that cause ne cause on each	ine.					-		ction		Approximate Interval Between Onset and Death
350	/Medical Examiner		resulting in death)	Due to (or as	s a conseque	ence of):								
	and transit	Examiner	S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a conseque									
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	ding h. After fune	ertification: T	27. Manner of Death  1. Natural 5 Pending 2 Accident investigation	28a. Date of Inj (Month, Da	urv 2	28b. Time of Injury		28c. Injury Work		280		now injury occur		<b>y</b> )
Division	P die	Certific	3 Suicide 6 Could not be determined	28e. Place of In building, e	ijury - At hom tc. (Specify)	ne, farm, str	eet, factor	y, office		28f	. Location (S City or Tox	Street and Numb vn, State)	er or Rura	al Route Number,
	Ho Fur ely	edicai (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	sician: To the besi iner: On the basis of and manner s	of examination	ledge, death on and/or inv	occurred restigation	at the time, in my op	e, date and inion, deat	d place, and th occurred	due to the at the time,	cause(s) and madate and place,	anner as s and due to	stated. o the cause(s)
	To the within 2 To the complete	M	29b. Signature and title of countrier	bul	h		290	D. License	number	34	29d. Date signed (Month, Day, Year)  January 30, 2006			
	2		30. Name and address of person who of Barry N. Rosenbar					Avenu	ie, Ke	ensing	ton,	MD 2089	5	
	Sta Registi		31. Date filed (Month, Day, Year)  JAN 3 1 2	32. Bygist	rar's Signatu	re K. A.	sell	,						

		For State Registrar			Department of F Certificate of		R	eg. No.	)	04199
Physici /Medic		Decedent's Name (First, Middle, L SAMUET		JONES	S		2. Date of Dea Feb	6, 20	<b>6</b> 6	3. Time of Dea 6:20P
Examin		4a. Facility Name (If not institution, g 2955 Grier Nu		a đ		r Location of Death t Hill		4c. County of Harfo		
Funeral Director		217–20–7670		e (In yrs. last birt	hday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day 9/28/19	Year)	Birthp Cour Mc.1	place (State or For htry) 11ano
show		Usual Residence of Decedent  10a. State 10b. County		10c. City, Towr	or Location				1	0d. Inside City Lin
28e-f sh	ctor	MD Harfor	<u>ද</u>	Fores	t Hill					1 ☐ Yes 2 🕅
ms 23e or 28e-f show rinust be notified at	Funeral Director	10e. Street and Number 2955 Grier Nurser	y Road		10f. Zip Code 2105	0	1	0g. Citizen of Wh USA	at Cour	ntry?
or Ite	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ፟XWidowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1  Yes 2 N If Yes, Give Year or Dates:		13. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race Black, Specify:	White,	etc.
netur	Completed	15. Decedent's (Specify only highest g Elementary/Secondary (0-12)	Education rade completed)  College (1-4or 5	4)	Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	during most of work	ing	16b. Kind of Busi		-
and Mental Hygiene. Is marked other then eumatic event, the Mi	To Be Cor	11 17. Father's Name (First, Middle, Las Thomas Scott Jo	•	D	airy Farmer	18. Mother's Name Jane Ma	e (First, Middle, i	Maiden Surname)		
f Health and Menitem 27 is marke other treumatic		19a. Informant's Name/Relationship Sarah J. DeBaugh			Mailing Address (Street 9 Pyle Road				ate, Zip	Code)
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Departme Importer any injur once.		21. Signature of un ral Service Lic		leto	22. Name and Addre Harkins		.,600 M	ſain St	.,D	elta.P
ysician Medical kaminer	Examiner	23a. Pany. Enter the disease, or observed to cause (Final disease or condition resulting in death)  Sequentially list conditions, if my learn the cause. Enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a Due to (or as a c.	a consequence of	2 Carres	3, 300, 40 64, 64, 64	or toophia ory an			Approximate Interval Betwee Onset and Dea
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De d	by	Part II. Other significant conditions  Callta		•	the underlying cause gru			bacco use contrib es 2 □ No 3		^
ate has been s page 2 should	Completed	denette					24a. Was a autops perform	ned? pri	or to co ath?	psy findings avai
is certificate director, pag	BeC	25. Was case referred to medical examiner?	Harrisol			26. Place of Deat				
this raldiu	. To	1 Yes 2 No 27. Manner of Death	Hospital: 1  Inpatie	nt 2 ☐ ER/Ou		4   Nursing no		ance 6 Other		y)
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24 hours after death be Funerel Director: A pletely filled in by the fi	edical Ce	29a. Certifier (Check only one) 1 Certifying F	Physician: To the best of aminer: On the basis of and manner sta	examination and	, death occurred at the tid d/or investigation, in my o	me, date and place, opinion, death occur	and due to the cred at the time, d	ause(s) and manr ate and place, an	ner as si	tated. the cause(s)
within 24 ho To the Fune completely fi	Med	29b. Signature and title of certifier	and manner sta		29c. Licens	e number	2	9d. Date signed (		
		David 5	2	<u> </u>	0	3 2 254		Feb 7,	20	Ub
		30. Name and address of person wh	o completed cause of de		Type, Print)	,	1 7 - 1	D 2101	1	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month -NS Physician 8 -200h 09:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HARBOR HOSPITAL CENTER BALTIMORE TY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb. 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min 1 ☐ M 2 🖫 F 73 577**-**48-0245 Yrs. Virginia Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Iteme 23e or 28e-f ehow the Medical Examiner must be notified at Millersville 1 ☐ Yes 2 XNo Maryland Anne Arundel by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 615 Waterwheel Lane 21108 United States 12. Was Deceden! Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker own home other treumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Depertment of Heelth and Mental Hy Important: If Item 27 ie marked oth eny injury or other treumatic event 17. Father's Name (First, Middle, Last) Be William Fitzue Lee Margaret Hensley ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald D. Johnston -husband 615 Waterwheel Lane Millersville, Maryland 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition
1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State Metropolitan Crematory 1/29/2006 Alexandria, Virginia 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications shock, or heart failure. List only one of Approximate Interval Betwee Onset and Dea Immediate Cause (Final disease or condition resulting in death) wee **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner anding physicien end use as the burial-transit S 90 that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be deteched 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 □ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed?
1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Nopatient ို 1 Yes 2 No 2 ER/Outpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Division of Vital Records,

the Hospital or Attending Physician: The lew requires that the death certificate be executed Japital ...
A hours after dea.
Arel Director: After within 24 hours a

State Registrar

4 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -

2006

31

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

32. Registrar's Signature

ADH	KIRKPA	TR	TCK							
)6 <b>-</b> 09		Y.T.1	Please Unpend item# 23a,	Type or Prin	nt in Black Inc 353,3/27/PG T	delible ink. Ens	ure All Copie and Mental H	s Are	Legible.	01.001
		•	1 - For State Registrar	Otate of Wie		tificate of Death		Reg. No.	UUU	04201
	Physicia	an	1. Decedent's Name (First, Middle, La	st)			2. Date of 0	Day	Yeer	3. Time of Death
	/Medic	al	David James K 4a. Facility Name (If nòt institution, gin			4b. City, Town, or Location	FEBRUA		, 2006 County of Deat	2144 P M
	Examin	er	WASHINGTON COUNT			HAGERSTOWN			ASHINGTO	
2	Funeral		Social Security Number     6. 3	Sex 7. Age	e (In yrs. last birthday)  5.4 Yrs.	If Under 1 Year If Under Months Days Hours		Day, Year)		thplace (State or Foreign buntry)
<i>io</i>	Director		178-44-2364 Usual Residence of Decedent		54 Yrs.		Nov 2	1951	Per	nnsylvania
	aryland show	_	10a. State 10b. County	ahan	10c. City, Town or Lo					10d. Inside City Limits Y Yes 2 No
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	h with		220 N. Potomac	st.		21740			U.S.A.	ŕ
	teme	Funerai	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13. \	Was Decedent of Hispanic Of Yes, specify Cuban, Mexico	Origin? (Specify Yes or I an, Puerto Rican, etc.)	No-	14. Race - Ame Black, Whit	
336	urs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ZYes 2 ☐ N If Yes, Give Year or Dates:	NO .	I□Yes 2∭XNo Specify	y:		Specify: [	White
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Important: It liem 27 is marked other than "natural", or iteme 23e or 28e-f show important: It liem 27 is marked other than "natural", or iteme 23e or 28e-f show eny injury or other traumatic event, the Marylaid Examiner must be notified at QDGs.	eted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Deced	lent's Usual Occupation kind of work done during mo DO NOT use retired)	ost of working	16b. K	ind of Business	/Industry
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Ma	nd 2 sl lith and 27 ie r r traur		Donald G. Kirkp	•		9 Hamilton B		-		
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Division of Vital Records,	or Atte	Certification:	3 Suicide 6 Could not 4 Homicide determined	200. Place of Inj	jury - At home, farm, str c. (Specify)	eet, factory, office	28f. Location City or	(Street ar Town, State	nd Number or R e)	lural Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2					h occurred at the time, date				
	in 24 h in 24 h ihe Ful ipletely	Medicai	one)	miner: On the basis o and manner st	of examination and/or in ated.	vestigation, in my opinion, de				
	To To COL	2	29b. Signature and title of certifier	In n		29c. License numbe	er		ute signed <i>(Mon</i> UARY 7,	
			30. Name and address of person who	comple ed cau e of c		Print)				
			5.72. HOG	H	de Cierra	111 PENN STRE	EET, BALTIMO	ORE, I	MARYLAN	D, 21201
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Amend item#5, perrif (2852, 2723/06 TI State of Maryland / Department of Health and Mental Hygiene 1- State Ragistrar Amend Item #17&18 Per FH G85@entificate@ffeath Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Florence P. Kendall **Physician** Jan. 28, 2006 9:20 p M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Sunrise Assisted Living Severna Park If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F 95 Yrs. 215-05-<del>5793</del> Director May 5, MN Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28e-f ehov treumstic event, the Madical Examiner trust be notified at 1 ☐ Yes 2 No Director MD Anne Arundel Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t. Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itame 23a or any injury or other treumatic event, If a Managare. 462 Oak Circle 21146 USA Completed by Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes 2 XNo 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health 5+ Physical Therapist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles August Peterson Mathilda Peterson 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan K. Nolte/Daughter 462 Oak Circle, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) Feb. 7, 20a Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Druid Ridge Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Merassanic **Physician** Lung disease or condition resulting in death) 515 /Medical Due to (or as a consequence of) mon M Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner use as the burial-transit or Attending Physician: The law requires thet the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy signed by the atte Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nas 2. No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation s after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 | Homicide within 24 hours a To the Funeral C completely filled pellil Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00051301

Registrar
DHMH 17 Rev 1/2001

State

900

37 Registrar's Signature

Besigne pd sute 300

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

TO

31. Date filed (Mohth, Day, Year)

JAN 3 1 2006

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 1:40 A M Anthony Kenosian 2006 January 31 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1⊠M 2□ F Yrs. Director June 2, 1915 011-12-1083 Massschusetts Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "naturel", or Items 23s or 28e-f show the Medical Examinar must be notified at 1 Tr Yes 2 □ No Maryland Carroll Mount Airy Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 713 Midway Avenue 21771 United States 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Peges 1 and 2 should be filed within 72 hours after Depertment of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel; or Ite, eny injury or other treumatic event, the Medical Examinat 1 ⊠ Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Major U.S. Army 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Avak Kenosian Zabel Mazmanian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Windsor / Niece 4701 Cowmans Court South Mt. Airy, Maryland 21771 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State February 4, 4 □ Donation 5 □ Other (Specify) Cedar Hill Cemetery Suitland, Maryland 2006 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 8 E. Ridgeville Blvd. Mt. Airy, Maryland 21771 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death Hontic **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner led by the attending physicien end detached for use es the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1□ Yes 2□No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospital or Attending F within 24 hours efter death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and title of pertition 29d. Date signed (Month, Day, Year) D-57796 31,2006 JAN UARY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 400 W. Seventh Street Frederick, MD 21701 Lalit Verma. M.D.

DHMH 17 Rev 1/2001

Registrar

FEB 0 1 2006

	4	For State Registrar	State of Ma		Departme Certifica				giene Reg. No.	000	0420	04
Physician		1. Decedent's Name (First, Middle, Last Dorothy Mari		ster				2. Date of De Feb.		200 <sup>Year</sup>	3. Time of 4:00	
/Medica Examine		4a. Facility Name (If not institution, give Memorial Hos					ocation of Deat		4c.	County of Death		
Funeral Director			াশ প্ৰচ	75	Yrs. If Un Month		If Under 24 Hrs Hours Min.		v, Year)	9. Birthp Coul 930 Luk	place (State ontry)	_
Maryland f show		Usual Residence of Decedent  10a. State 10b. County  MD Allegar	ny	10c. City, Town						1	10d. Inside Ci	ity Limits
with the	Direc	10e. Street and Number 21412 McMulle	n Highwa	w SW		Zip Code 21557	<del></del>		-	izen of What Coul	ntry?	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event. I'm Medical Exert are triust by inclined at 2006s.		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent E Armed Forces? 1 Yes 2 N	ver in U.S.	13. Was De If Yes, s	cedent of Hisp pecify Cuban,	panic Origin? (S Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)	US	14. Race - Americ Black, White,	etc.	
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perrit. Page Department of Important: If any injury or once		21. Signature of Funeral Service Licens	lifer		22. Name	and Address Nati	<sup>of Facility</sup> Ha	afer Fu	ner aVa	al Serv le, MD	rice, 2150	
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2		30. Name and address of person who c		111		υQ	D540C	m 1	0.1	02/00 502 DR	SHIN	C. 21.3
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		For State	State of Ma	aryland .	•	artment of F			200	16 01.205
		Registrar  1. Decedent's Name (First, Middle, La	st)		001	incate of	Death	2. Date of Dea	eg. Noi U U	3. Time of Death
Physicia		LAURA CONDRY LAF	•					FEBRUA!	Day	/ear
/Medic Examin	_	4a. Facility Name (If not institution, giv				4b. City. Town. o	or Location of Deat		4c. County of	
Examin	lei	ST VINCENT de PA		CENTI	ER	FROSTB			ALLE	
Funeral Director		Social Security Number     6. S		e (In yrs. last		If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		Year)	9. Birthplece (State or Foreign Country) 1ARYLAND
P .		Usual Residence of Decedent								
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or Itama 23a or 28a-f show armarked other than "natural", or Itama 23a or 28a-f show armaric event, the Macilcal Examinar must be notilised at	ž	10a. State 10b. County		10c. City, T						10d. Inside City Limits  M☐ Yes 2 ☐ No
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r Itan	Funeral	1 Never Married 2 Married	Amed Forces?			f Yes, specify Cub	an, Mexican, Puèr	to Rican, etc.)		White, etc.
ral', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 □ Yes 2X□ No	Specify:		Specify:	WHITE
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permit. Pages Department of h Important: If its any injury or of		21. Signature of Funeral Service Licer	1500		22	2. Name and Addre	ss of Facility	6	O W. MAI	N ST.
90 E 29		Man M So	wess m	00547	SO	WERS FUNI	ERAL HOME	, P.A. F	ROSTBURG	, MD 21532
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the all	slci	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	lime of death	h 5[	Other (specify)	·		Mon	ii Day real
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g Phy er this eral c	H .	27. Manner of Death	28a. Date of Inju	ry 28	b. Time o	f 28c. Inju	ry at		ow injury occurred	
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To the Hospital or Attanding Physician: within 24 hours after death.  To the Funaral Diractor: After this certifical completely filled in by the funeral director,	edical	(Check only 2 Medical Exa	nysicien: To the best	f examination	dge, deat and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occ	e, and due to the d urred at the time, d	ause(s) and mani late and place, an	ner as stated. Id due to the cause(s)
o the ithin 2 o tha	Med	one) 29b. Signature and title of certifier	and manner sta	ateu.		29c. Licens	se number	2	29d. Date signed	(Month, Day, Year)
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DHMH 17 Rev 1/2001

State

Registrar

Terrace Frostburg

MD 21532

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WONSOCK SHIN MD

FEB 1 4 2006

31. Date filed (Month, Day, Year)

48 Tarn

32. Registrar's Signature

			For State Registrar	State of Maryla		artment of F rtificate of			giene Reg. NZ ()	06 04206
*	Physici /Medic		Decedent's Name (First, Middle     Dorothy Mar	ie Linehan				2. Date of De Month  Jan 3	Day 1 2006	
2	Examin	er	4a. Facility Name (If not institution 11515 Lariat	, give street and number)		4b. City, Town, o	r Location of Deat	h		nty of Death lvert
塘	Funeral Director		5. Social Security Number 577-36-1756	6. Sex 7. Age (In y.	rs. last birthday, Yrs.	Months Days	If Under 24 Hrs Hours Min.		4 192	9. Birthplace (State or Foreign Country) 25 Virginia
	tryland show	_	Usual Residence of Decedent  10a. State 10b. County		City, Town or L	ocation				10d. Inside City Limits 1 ☐ Yes 2 🏋No
	the Ma 28a-f	recto	Maryland Calv	ert L	usby	10f. Zip Code			10g. Citizen o	of What Country?
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980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examiner must be multiled at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Marri 3 Widowed 4 Divorced	If Yas Giva	1 U.S. 13.	Was Decedent of H II Yes, specify Cub 1 Yes 2 XNo	tispanic Origin? (\$ an, Mexican, Puer Specify:	Specify Yes or No to Rican, etc.)		Race - American Indian, Black, White, etc. Icify: white
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	nd 2 sho alth and A 27 is ma r trauma		19a. Inlormant's Name/Relations Harold G. LIn	nehan-husband	11515	Lariat I	Lane Lust	oy Maryl		wn, State, Zip Code) 657 –
lore,	ages 1 and of Hes		20a. Method of Disposition 1 Burial 2 Cremation	20t	cemetery, cre	osition (Name of omatory or other pla	Feb 3	Date 2006		sburg, Maryland
Baltimore,	permit. Pa Departmer Important any injury		4 ☐ Donation 5 ☐ Other (S)  21. Signature of Funeral Service	pecity)	TE TITLE	coln Ceme  2. Name and Addre	rery			
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,092	ate be executed hysician and the burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (or as a cons	sequence of):					
89	g physi as the b	edical		d.						
.O. Box	that the death certifica ed by the attending ph detached for use as It	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time of 9 □ Unknown	etal death 3	□Ectopic pregnanc □ Other (specify) _	у		1	Date of delivery Month Day Year
S, D	The law requires that the site has been signed by the bage 2 should be detache	by	Part II. Other significant condition	ns contributing to death but not	resulting in the	underlying cause giv	ven in Part I.		tobacco use co	contribute to the cause of death?
Vital Record	: The law re cate has bed page 2 sho	Completed						24a. Was auto perf 1  Yes		bb. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:	ER/Outpatie	ent 3 DOA Ott	26. Place of De	Home 5 Bes		Other (Specify)
C C O 1 Natural 5 Pending (Month, Day Year) Injury Work?										
Division	after dea Director	Certification:	3 Suicide 6 Could of determined		t home, larm, s	treet, lactory, office			(Street and Nu own, State)	umber or Rural Route Number,
-	To the Hospital or Attency within 24 hours after death To the Funeral Director: completely filled in by the 1	edical C	29a. Certifier 1 Certifyin (Check only 2 Medical one)	ng Physician: To the best of my Examiner: On the basis of exam and manner stated.	knowledge, dea nination and/or i	ith occurred at the ti nvestigation, in my	me, date and place	e, and due to the urred at the time	cause(s) and date and place	manner as stated. ce, and due to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifie	r		29c. Licens		,		gned (Month, Day, Year)
	м		30. Name and address of person	W. Bennell of who completed cause of death (			25156	2	Janua	ary 31 2006
	1		Charles W	N Rennett M.D.	н.с. т		. LUsby	MD 20657	7	
-	Sta Regist		31 Date liled (Month Day Year)	32. Registre's Si	gnature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death JANVA RY 292006 8.54 PM **Physician** BARBARA /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Columbia

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Sept. 5, 1937 Howard Howard County General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 ☐ M 2 💢 F 577-50-8679 68 Yrs. Director Washington, DC Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23s or 28s-1 show other traumatic event, the Medical Examinar must be inclified at 1 ☐ Yes 2 No MD Anne Arundel Severn Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7917 Severn Tree Blvd. 21144 U.S.A. Completed by Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 homemaker own home 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any jury or other traumatic event 2008: 18. Mother's Name (First, Middle, Maiden Sumame) Be Antonio Catena Ruth Fearson ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edna Trentalance, daughter 7917 Severn Tree Blvd., Severn, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Ft. Lincoln Cemetery 02-06-06 Brentwood, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Rausch Funeral Home, P.A., Owings, MD 20736 1a 23a. Part1. Enter the disease, or complice shock, or heart follure. List only on mplir ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by or a cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic small cell carcinoma of Lung **Physician** disease or condition resulting in death) /Medical Examiner Genal Difcase End Stay Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed certificate 1 Yes 1 ☐ Yes 2 ☐ No 25 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗸 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural after death. Director: After Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No ☐ Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide õ To the Hospital within 24 hours. Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 30641 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neek food Ballimme maybed 2/22 Sabapathy 201-109 Back Kine 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			1 - State of N Registrar	•	epartment of Health Certificate of Deat		tal Hygieņ Reg. N	2006	04208
1.5	Physicial		1. Decedent's Name (First, Middle, Last)				Date of Death Month D	ay Year	3. Time of Death
	Physicia /Medic	. 40	Grace Virginia Lowman				nuary 2		2:30a м
	Examin	er	4a. Facility Name (If not institution, give street and number	r)	4b. City, Town, or Locatio	on of Death	4	c. County of Dea	th
		\$ "	835 Clifton Avenue	han the sun land hinth of	Arnold	der 24 Hrs.   g r	3-1 ( B: 45	Anne A	
	Funeral Director		5. Social Security Number 6. Sex 7 6. Sex 1 M 2 X F	Age (In yrs. last birthd 79 Yrs	Months Days Hours	rs Min. (	Date of Birth Month, Day, Yea LT. 15,	r) 9. B(r	thplace (State or Foreign ountry)
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ryland	how		10a. State 10b. County	10c. City, Town o		•			10d. Inside City Limits
е Ма	or 28a-f ehow e notified at	Director	MD Anne Arundel		Arnold	l 			1 ☐ Yes 2X No
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ath v	e 23e	ra	835 Clifton Avenue		2101:			US	
ter de	Tem Der D	Funeral	11. Marital Status 12. Was Decede Armed Force 1 □ Never Married 2 ★ Married 1 □ Yes 2 €	of Ever in U.S.	<ol> <li>Was Decedent of Hispanic If Yes, specify Cuban, Mexic</li> </ol>	Origin? (Specify ican, Puerto Rica	Yes or No- n, etc.)	14. Race - Ame Black, Whi	
urs af	l', or	by	3 Widowed 4 Divorced Year or Date:	3:	1 ☐ Yes 2 No Speci	city:		Specify:	White
filed within 72 hours after death with the Maryland	"natural", or Iteme 23a idical Examiner must b	ted	15. Decedent's Education	16a. De	ecedent's Usual Occupation		16b.	Kind of Business	/Industry
thin 7	Med.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12) College (1·4c)	- lin	ive kind of work done during m e. DO NOT use retired)	nost of working			
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be fi	and Mental Hygiene. Is marked other then aumstic avent, ILA Mi	Be	17. Father's Name (First, Middle, Last)			other's Name (Fir		n Sumame)	
should be	d Mer narke natic	ဥ	Michael Chiappe  19a. Informant's Name/Relationship (Type, Print)	105.14		nesta Pi		T 0	71.0.11
d 2 s	than		Bruce Albert Lowman/Husbar		alling Address (Street and Num 35 Clifton Ave			21012	Zip Code)
, - a	t of Health and Mental Hygiene. If Item 27 is marked other then "natural", or Iteme 23a or 28a-f ehov or other traumatic avent, It a Medical Examiner must be notified at		20a. Method of Disposition	20b. Place of Di	sposition (Name of	Date	20c.	Location - City or	Town, State
Pages 1	ent of ht: If I		1   Burial 2 □ Cremation 3 □ Removal from Sta  □ Donation 5 □ Other (Specify)	Θ	crematory or other place) UMC Cemetery	Feb. 1		nold, MI	)
ermit. F	Department of Health a Important: if Item 27 is eny injury or other traisone.		21. Signature of Funeral Service Licensee	-	22. Name and Address of Fac Barranco & Soi	ns. P.A.	Severna	a Park F	uneral Home
<b>.</b>	0 E • 0	3	23a. Part1. Enter the disease, or complications that cause	ed the death. Do not	495 GOV. RILCI	me Hwy,	Severn	a Park,	MD Z1146 Approximate
Ph	ysician		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition		IL CANCER	3			Interval Between Onset and Death
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a di	* ** ***	er		as a consequence of):					
petn	dansit	Examiner	cause, Enter Undertying Cause (Disease or injury that initiated events						of district or the second seco
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ificate be executed	physician and s the burial-transit	edical	d						
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ath c	attend for us	lan/	23b. Was decedent pregnant in the past 12 months?	2 Fetal death	3 Ectopic pregnancy			23d. Date of de Month	livery Day Year
he de	been signed by the attending should be detached for use a	Physician/M	1 ☐ Yes 2 ☐ 4 ☐ Pregnant 9 ☐ Unknown 9 ☐ Unknown	at time of death	5 Other (specify)				
that	deta		Part II. Other significant conditions contributing to death	but not resulting in th	e underlying cause given in Pa	art I.	23e. Did tobacco	use contribute to	o the cause of death?
anires a	n sign uld be	ed by					1 🗌 Yes	2 □ No 3 □ P	robably 4 Unknown
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hysic	his ce	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpa			Nursing Home		6 ☐Other (Spe	ecify)
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ttend	death stor: ,	icat	2 Accident investigation 3 Suicide 6 Could not be 288 Place of	njury - At home, farm	M 1 Yes 2		ocation (Street	and Number or O	lural Route Number,
al or A	s after al Director ed in by	Certification;	4 Homicide determined 289. Place of building,	etc. (Specify)	, street, factory, office	201. 1	City or Town, Sta	te)	urar Houle Number,
To the Hospital or Attending Physician: The law requires that the death certi	within 24 hours after death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2.	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the besidence on the property of the control of the control of the certified on th	of examination and/o	eath occurred at the time, date or investigation, in my opinion, c	e and place, and death occurred at	due to the cause( t the time, date a	s) and manner a nd place, and du	s stated. e to the cause(s)
To the	within To th compl	Me	29b. Signature and title of certifier		29c. License numbe	Der	29d. D	ate signed (Mon.	th, Dey, Year)
			> YEAR Sith SI.	mo	7307	101	11	30/200	16
			30 Name and address of person who completed cause of ROBERT SCOTT EDEN, M.D.	f death (Item 23a) (Ty	pe, Print) dieal Phury, AN	VNAPOUS.	MAZ	1401	
	Sta	_	31. Date filed (Month, Day, Year) Regi	strar's Signature	1 - May / IN	17711000	111111111111111111111111111111111111111	101	
	Registr	ar	JAN 3 1 2006	US A					

			For State Registrar	State of M	laryland	/ Depa	artmen	t of Health a	and M	ental Hyg		06	0420	)9
	Physici	an	1. Decedent's Name (First, Middle	e, Last)		Т				2. Date of Deat Month	_	Yea	3. Time of	
	/Medic	cal	Ethe1 4a. Facility Name (If not institution	a sixo atrost and sumbar		Lo		Town, or Location		January			<del>_</del>	). M
	Examin	ıer	Kline Hospice	_	)			Airy	or Death			ounty of De dericl		
F	uneral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las	st birthday)	If Under	1 Year   If Under	24 Hrs.	8. Date of Birth (Month, Day,		9. B	irthplace (State or	r Foreign
	irector		220-16-0635	1  M 2	80	Yrs.	Months	Days Hours	Min.	ugust 3	1, 1	925	Country) Maryland	
and	W.		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside Cit	v Limits
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the	or 28a e noti	irec	10e. Street and Number		111000	TICK	10f. Zip	Code		1	0g. Citize	n of What	Country?	
ath wi	23a c	rai	800 Motter Aver	nue			21	701			U.	S.A.		
CI CIC IS-UUSO filed within 72 hours after death with the Maryland	Items Der Di	Funeral Directo	11. Marital Status	12. Was Deceden Armed Forces	?	13. \	Was Deced If Yes, spec	ent of Hispanic Ori ify Cuban, Mexicar	igin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)	14	. Race - An Black, Wi	nerican Indian, hite, etc.	
DOOS hours aft	ار. الم	by F	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☑ Divorced	If Vac Give			1□Yes a	≥ No Specify:	:		S	pecify:	white	
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yland buld be fil	red of	Be c	William MCGa	,					<sub>ers Name</sub> y Hef	(First, Middle, M	vaiden S	umame)		
shoul	mark	္	19a. Informant's Name/Relations			19b. Mailir	ng Address	(Street and Number			City or	Town, State	, Zip Code)	
and 2 sh	altra 27 la er treu		Gloria Thompson	n – daughter				Avenue,					21701	
es 1 s	f item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2 □Bomoval from State	_   сеп	ce of Dispo	natory or of	ther place)					or Town, State	
Pag	tent: I		*4 □Donation 5 □ Other (S	Specify)	Rest	haven			1–30–	-2006 F	rede	rick,	Marylan	d
permit. Pages	Department of resett and wetter hygories. The property of thems 23s or 28s-f show more in them 27 is marked other than "natural", or them 23s or 28s-f show any injury or other treumetic event, if a Medical Eracid or must be notified at ODCs.		21. Signature of Funeral Service	Muelle (	lin			d Address of Facili	. 3	tauffer ke, Fre				21702
			23a. Part1. Enter the disease, or shock, or heart failure. List	r complications that cause only one cause on each	ed the death. line.	Do not ent	er the mod	e of dying, such as	cardiac or	r respiratory arre	est,		Approximate Interval Bety	ween
	ysician		Immediate Cause (Final disease or condition resulting in death)	-a Cong	estive	Henri	FA1	LURE					Onset and D	eatn
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ecords law requires	ould b		Anoxic ence	ph dop why						1 🗆 Ye	s 2 🗆	No 3	Probably 4 🗷 U	nknown
aw C	as be	ompieted		<u></u>						24a. Was a autops	y	prior t	autopsy findings a o completion of ca	available
The Th	s certificate has b lirector, page 2 s	Son								perform 1 Yes 2	No No	death'	? es 2□ No	
VILCIII	is certific director,	o Be	25. Was case referred to medical examiner?	Hospital:						(Check only on			Kline	
VISION OF VITA	. 20 ℃	Η,	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of In		R/Outpatier 8b. Time of		8c. Injury at Work?		ne 5 Reside			Decity) Hospi	ce
VISION	r: Afte e fune	ation	1 ☑Natural 5 ☐ Pendin 2 ☐ Accident investi	19	lay Year)	Injury	М	Work? 1 ☐ Yes 2 ☐	No					
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he Hosp	within 24 nouts effect dearn. To the Funeral Director: Affect the completely filled in by the funeral	edical	29a. Certifier 1/ Certifyir (Check only 2 Megfical one)	ng Physician: To the bes Examiner: On the basis and manners	of examinatio	edge, deatl on and/or in	h occurred vestigation,	at the time, date an in my opinion, dea	nd place, a ath occurre	and due to the ca ad at the time, da	ause(s) a ate and p	nd manner lace, and d	as stated. ue to the cause(s)	ı
Tot	To T	Σ	29b. Signature and title of certifie	* y	//		29c	License number	2	2	9d. Date	1 /	nth, Day, Year)	
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,	(		30. Name and address of person Eugene Casas	grande	1564	Oposs		m Pike,	Frede	erick, M	ary1	and	21702	
ķ.	Sta Registr		31. Date filed (Month, Day, Year)	1 2006 32. R	trar's Signatur	re K	best							

			For State Registrar		State	e of Ma	ryland				lealth a		ental Hy	giene	16	04210		
*,	Physicia /Medic		Decedent's Name	e (First, Middle		iel L	EIBO						2. Date of De Month	eath Day	Year	3. Time of Death		
0	Examin		4a. Facility Name (		-		DAME	D			Location			4c. Coun	ty of Death	2.00,1		
	Funeral		5. Social Security N		6. Sex			K ast birthday)	If Unde	r 1 Year			8. Date of Bir	rth	OMICO 9. Birtho	lace (State or Foreign		
¥	Director		057-20-9		1 □ M 2 🖸	( -	78	Yrs.	Months	Days	Hours	Min.	(Month, Da	1927 <b>1927</b>	Cour	York		
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21215-0036 within 72 hours all	an "natura Mudical E	Completed by	(Spec	15. Decedent'	grade comple	ited) ige (1-4or 5+	.)	16a. Deced (Give life.	dent's Usu kind of wo DO NOT u	rk done d	durina mos	t of workir	ng	16b. Kind of	Business/Ind	dustry		
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aryla	mark matic	오	19a. Informant's N			)		19b. Mailir	na Address	S (Street a			na (unknown)  r or Rural Route Number, City or Town, State, Zip Code)					
A M	ealth a m 27 is ner treu		David Le		z, Son				. Mai	in St				on, OH				
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8760,	physiclen the burial	dical			d													
ox 6		/Mec	IF FEMALE: 23b. Was deceden		23c. If yes	s, outcome of	f pregnar	ncy						22d D	ate of delive	n,		
O. Box	igned by the atter be detached for u	Physician/Me	in the past 12 1 Yes 2 9	months? ■No	4 P	ive birth 2 Pregnant at ti Inknown			Ectopic produced of the second							Day Year		
'ds, P	signed b	þ	Part II. Other signif	ficant condition	ns contributing	to death but	not resu	Iting in the u	nderlying o	ause give	en in Part I	•	23e. Did 1	/	/	e cause of death? ably 4 ∐Unknown		
00 %	as been si 2 should	ojete											24a. Was	an 24b	. Were auto	osy findings available		
- Re I	ate ha	Completed											auto perfo	psy prmed? 2 No	prior to cor death? 1  Yes	osy findings available inpletion of cause of 2 No		
/ita	artific ctor,	Be (	25. Was case refer examiner?	red to medical							26. Place	of Death	(Check only					
of √	his or	2	1 ☐ Yes 2 ☐			1 🗌 Inpatient		R/Outpatien		1	100000	rsing Hom	ne 5 🗆 Resi	dence 6 🗆 Ot	ther (Specify	")		
O'n' C	After funere	lon:	1 ☑√atural 5 ☐ Pending (Month, Day Year) Injury Work?											how injury occu	ırred			
Division of Vital Records, P.O. Box 6	within 24 hours after death.  To the Funeral Director: After this certificate ha completely filled in by the funeral director, pege	Certification;	2 Accident 3 Suicide 4 Homicide	6 Could no	at ho	Place of Injur building, etc.	y - At hor (Specify)	me, farm, str			163 2		8f. Location ( City or To	Street and Num wn, State)	nber or Rura	l Route Number,		
Hospit	n 24 hours ne Funera pletely fille	Medicai (	29a. Certifier (Check only one)	12 Certifying 2 Medical E	xaminer: On t	o the best of he basis of e manner state	examınatı	vledge, death on and/or inv	occurred vestigation	at the tim , in my op	e, date an pinion, dea	d place, a th occurre	and due to the	cause(s) and n date and place	nanner as st	ated. the cause(s)		
Tot	withi.	ž	29b. Signature and	title of certifier	1//	,			290	c. License	number	(	2	29d. Date sign	ed (Month, I	Day, Year)		
			1//	1010	Yas				9	221	97	4)		/30/	86			
	10		30. Name and addr							SBID	<b>У</b> , мг	) - 2	1804	'				
	Sta	te			3	200 CI 32. Pygistrar			DAPT	DOUK.	- , t.1F	. 2.	T004					
No.	Registra	ar	31. Date filed (Mon	JAN 3	1 2006	A Best A	ری	1. B	meri									

	1 - State Regist
Physician	1. Deceden
/Medical Examiner	4a. Facility
Examine	1310

**Funeral** Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: if item 27 is marked other then "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exaction arrival be recitied at once.

> **Physician** /Medical Examiner

> > within 24 hours after death.
> >
> > To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State of Maryland / Department of Health and Mental Hygiene

	1 - State Registrar		Certific	cate of Deat	h	R	eg. No. 0 0 E	04211			
М	Decedent's Name (First, Middle, Last)	)				2. Date of Dear Month	_	3. Time of Death			
an al	Richard	Louis	Meador			January	00 000	- I M			
al er	4a. Facility Name (If not institution, give	street and number)	4b.	City, Town, or Location			4c. County of I				
•	1310 West Mt. Har	mony Road		Owings	3		Calve	ert			
ï	5. Social Security Number 6. Sec			Inder 1 Year   If Und	er 24 Hrs.	8. Date of Birth (Month, Day	Year) 9.	Birthplace (State or Foreign Country)			
	579-36-1469 <sup>1X</sup>	<sup>2M 2□ F</sup> 75	Yrs.	nths Days Hours	s Min.	Mar. 2		Wash., D.C.			
	Usual Residence of Decedent							1			
	10a. State 10b. County	10c. Ci	ty, Town or Location	1				10d. Inside City Limits			
tor	MD Calvert Owings										
rec	10e. Street and Number		10	f. Zip Code		1	0g. Citizen of Wha	t Country?			
	1310 West Mt. Har	mony Road		20736			USA				
Completed by Funeral Director		12. Was Decedent Ever in U	J.S.   13. Was I	Decedent of Hispanic	Origin? (Spe	cify Yes or No-	14. Race -	American Indian,			
ם	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑ Yes 2 ☐ No	If Yes	, specify Cuban, Mexi	can, Puerto F	Rican, etc.)	Black, 1	ick, White, etc.			
by	3 ☐ Widowed 4 ☐ Divorced	If Pes, Give Year or Dates: 1952	-54 1□Y	es 2X No Spec	rty:		Specity:	white			
eq	15. Decedent's Edu		16a. Decedent's	Usual Occupation			16b, Kind of Busin				
piet	(Specify only highest grad		(Give kınd life. DO N	of work done during rr OT use retired)	ost of workir	ng					
E	Elementary/Secondary (0-12)	College (1-4or 5+)	union	painter			constru	ction			
Ö	17. Father's Name (First, Middle, Last)			-	ther's Name	(First, Middle,	Maiden Sumame)				
To Be	Louis Archer	Meador		El	ma	Eloise	e McG	hee			
-	19a. Informant's Name/Relationship (7)		19b. Mailing Ad	dress (Street and Nur	nber or Rura			te, Zip Code)			
	Jo Ann Meador, wi	fe	1310 1	Mt. Harmon	v Road	l. Owing	as. MD 2	0736			
	20a. Method of Disposition		Place of Disposition	(Name of		ate	20c. Location - Cit	y or Town, State			
	1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	nithville		02-02	2006	Dunkirk,	MD			
	21. Signature of Funeral Service Licens			ne and Address of Fa	1	-2000	Daritten,				
	11) (VICAN -	8 C.		sch Funera		2 D 7	Owings	MD 20736			
	23a. Part1. Enter the disease, or comp	lications that caused the dea						Approximate			
	shock, or heart failure. List only one cause on each line.										
	Immediate Cause (Final disease or condition resulting in death)  PULMONARY FIBROSIS										
		Due to (or as a conse									
-	Sequentially list conditions, if any leading to immediate  AS BESTOSIS  Due to (or as a consequence of):										
lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 03 0 00130	<b>quotico</b> 017.								
хап	that initiated events resulting in death) Last	c	quence of):								
E		2010 (01 00 2 001100	4001100 01).								
Medical Examiner		d									
Me	IF FEMALE:	00- 11									
lan	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregr 1☐Live birth 2☐Fet	al death 3 Ecto	pic pregnancy			23d. Date of Month				
sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death 5 □ Oth	er (specify)							
Phy	Part II. Other significant conditions co	patchuting to death but not re	sulting in the under	vice course succe in Da	et 1	23a Did to	hacco uco contribu	ite to the cause of death?			
by	Faith. Other significant conditions co	orthodaling to death but not re	suiting in the under	ying cause given in Fa			/	☐ Probably 4 ☐Unknown			
ted							65 22 140 3				
autopsy performed? death?  1								re autopsy findings available r to completion of cause of			
								th?			
0	examiner?	Hospital: 1 ☐ Inpatient 2 [	□ER/Outpatient 3	DOA Other: 4	Nursing Hor	ne 5X Resid	ence 6 Other	(Specify)			
T:U	27. Manne of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	1	28d. Describe h	ow injury occurred				
atio	1 Natural 5 Pending 2 Accident investigation			1 □Yes 2	□No						
HC	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At building, etc. (Spec	home, farm, street,	actory, office		28f. Location (S	treet and Number	or Rural Route Number,			
ert	4  Homicide	building, etc. (Spec	ary)			City or Tow	m, State)				
al C											
	29a. Certifier 12 Certifying Phy	ysician: To the best of my kr	nowledge, death occ	urred at the time, date	and place,	and due to the o	cause(s) and mann	er as stated.			
Medical Certification:	29a. Certifier 1 Certifying Phyone) 2 Medical Exem	ysician: To the best of my kr liner: On the basis of examin and manner stated.	nowledge, death occ nation and/or investi	urred at the time, date gation, in my opinion,	and place, a death occurr	and due to the ded at the time, of	cause(s) and mann date and place, and	er as stated. If due to the cause(s)			

State Registrar

29b. Signature and title of certifier

M.D., 310 Hospital Rd., Ste. 310, Prince Frederick, MD Peter Wisniewski, 32. Registres Signature 31. Date filed (Month, Day, Year) 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D40370

			1 - For State Registrar	State of M	laryland /		artment of rtificate o				giene No. 0 0 (	5 04212
261	Physici	an	Decedent's Name (First, Middle, La	*					-	2. Date of Dea Month	_	3. Time of Death
	/Media	cal	Charles Henry  4a. Facility Name (If not institution, giv				45 Oib. Town			Jan.		006 6:20 p M
	Examir	ier	Millenium Sout				4b. City, Town				4c. County of	
	Funeral		5. Social Security Number 6. S		ge (In yrs. last i	birthday)	if Under 1 Yea	gewa	nder 24 Hrs.	8. Date of Birth		ne Arundel  B. Birthplace (State or Foreign Country)
*	Director		579-70-0717	M 2□F	57	Yrs.	Months Day	/s Ho	urs Min.	Jul. 1	8,1948	Washington, DO
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wm or Lo	cation					
	Maryli f eho	ō	MD Anne Ar	undel	Too. Ony, to	74411 07 120	Tracy	s La	nding			10d. Inside City Limits 1 ☐ Yes 2X No
	r 28a-	rect	10e. Street and Number			-	10f. Zip Code				10g. Citizen of Wh	at Country?
	h with	a D	171 Deale Road					2075°	1		Ü	JSA
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23e or 28e-f show any njury or other traumatic event, I'm Medical Eventinar must be notified at ADRC.	by Funeral Director	11. Marital Status  1 ※Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces' 1  Yes 2 If Yes, Give Year or Dates:	? No			f Hispani uban, Me	c Origin? (Sp xıcan, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
2	72 ho	ed	15. Decedent's Ed (Specify only highest gra	ducation	16	Sa. Deced	dent's Usual Occ	cupation	most of work	ing	16b. Kind of Busi	ness/Industry
2	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)		kind of work dor			9	Пъс	e Service
22	Hygier than the	Ö	12 17. Father's Name (First, Middle, Last)			Tre	e Servi			a /First Middle	Maiden Sumame)	ee pervice
and	d be i	To Be	David Mavity							L. Moor		
ary	shou and M amer umat	۲	19a. Informant's Name/Relationship (	Type, Print)	15	9b. Mailir	g Address (Stre	et and No	umber or Run	al Route Numbe	r, City or Town, St	ate, Zip Code)
Σ	and 2 saith a n 27 i		David Mavity/Bro	ther		6307	Summer	Sky	Lane,	Green A	Acres, FI	33463
Baltimore,	Pages 1 ment of He ant: If Item ury or oth		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ 4 □ Donation 5 □ Other (Specific		20b. Place Cemel Met	of Dispo tery, cred TO	sition (Name of patory or other of TEMATOL	y Y	Jan	28, 2006	20c. Location - Ci Baltin	ty or Town, State
Balt	permit. Depart Import any nj		21. Signature of Funeral Service Licer	Allen	V						erna Park erna Park	Funeral Home , MD 21146
8760,	Physician /Medical Examiner	Ical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acut Due to (or as	ine.	e of): He		-1.	n Com		esi,	Approximate Interval Between Onset and Death Dea
P.O. Box 68	The law requires that the death certifics lie has been signed by the attending ph page 2 should be detached for use as it	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		Ectopic pregnar				23d. Date of Month	
	uires that signed bi id be deta	by	Part II. Other significant conditions of	ontributing to death t	out not resulting	in the ur	nderlying cause (	given in P	art I.			ute to the cause of death?  ☐ Probably 4 ☐ Unknown
Division of Vital Records,	he law requir e has been si age 2 should l	Completed								24a. Was a autops perform	med?   dea	re autopsy findings available or to completion of cause of ath?
a		BeC	25. Was case referred to medical					26 P	Place of Death	1 Yes		Yes 2□ No
>	ysici nis cer direc	ToB	examiner? 1 ☐ Yes 2 ∰ No	Hospital: 1 ☐ Inpati	ent 2 ER/C	Dutpatien	t 3 DOA				ence 6 Other	(Specify)
0	Attending Physician: The rideath. ector: After this certificate hat the funeral director, page		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b	. Time of Injury	28c. In				ow injury occurred	
<u>S</u>	tendi death. tor: A the fu	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be					☐ Yes				
	after deat Director:	Certification:	4 Homicide determined	286. Place of in	ce of Injury - At home, farm, street, factory, office Iding, etc. (Specify)  28f. Location (Street and Number or Rural Route North City or Town, State)							or Rural Route Number,
	spita hours ineral y filled	Medical C	29a. Certifier (Check only one)	ysician: To the best niner: On the basis of and manner st	of examination a	ge, death and/or inv	occurred at the restigation, in my	time, dat opinion,	e and place, death occurr	and due to the c	ause(s) and mann ate and place, and	er as stated. I due to the cause(s)
	To the Ho within 24 To the Fu completel	Me	29b. Signature and title of certifier	4			29c. Lice			2	9d. Date signed (/	Month, Day, Year)
			30. Name and address of person who	completed cause of	death /Item 22a	) (Tuno		385	65		Smuch	27,2006
200			( )	back	134	)(Type, I	ens. Il	f R	0 1	wast (	Bloor	mp
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sta Registr		31. Date filed (Month, Day, Year)	32. A gistr	rar's Signature	1 19	back					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year McCartney 3:30 PM arrell January 29. 2006 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore University of Manyland Medical System If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year JAN, 19, 1 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F 73 Director West Virginia 232-50-0566 1933 Usual Residence of Decedent with the Maryland 10a, State 10c. City, Town or Location 10b. County 28a-f show 10d. Inside City Limits the Medicul Examiner must be notified at Maryland Frederick Middletown Director 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8897 238 Gloria Ave. 21769 United States death Funera Itame 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1951-55 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 🗓 No þ Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) 5 + Elementary/Secondary (0-12) Accountant Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame, Be and Mental David McCartney 0rpha 2 Luvada 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i Nancy S. McCartney / Wife 8897 Gloria / Middletown, Maryland 21769 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1 Department of F Important: If ite any injury or ot once. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Frederick Crematory Feb. 1, 200 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike/ Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Preumonia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 weeks AML Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Una to (or as a nonsequence of) physicien and s the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760, Completed by Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery atter for u 3 DEctopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ finknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cete hes 1 ☐ Yes 1 ☐ Yes 2 ☐ No 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Hhpatient Other: 1 ☐ Yes 2 ☑ No ٩ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA this After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🖾 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the Director. 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dire 4 Homicide Hospitel 1 certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Limited Examines: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical To the and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 37 29.2006 MD January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 South Greene St. Baltimore M.D SIK HUIZ 31. Date filed (Month, Day, Year) 32. gistrar's Signature State FEB 0 1 2006 Registrar

			1 - For State Registrar		Maryland / De	partmen ertificate			and M		giene Reg. No.	UUI	5	0421	par Trus examinado				
ı	Physici		Decedent's Name (First, Middle Madelyn Roche							2. Date of De Month Janua		, 2Č	ear 106	3. Time of De 3:10					
	/Media Examir		4a. Facility Name (If not institution	n, give street and nun			Town, or	Location o	f Death	Janua	_	County of		3:10	A				
			3114 Gracefiel					Sprin	-			ontgo							
	Funeral Director		5. Social Security Number 484-18-2571	6. Sex 1 ☐ M 2√2 F	7. Age (In yrs. last birthda 82 Yrs	Months	Days	If Under 2 Hours	Min.	8. Date of Bird (Month, Da Sept. 25	y, Year) $192$	23	. Birthpla Count Iowa	ace (State or F ry)	oreign				
	land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location		-	-				10	d. Inside City	Limits				
	a-f sh	tor	Maryland Montg	omery	Silver	Spring	g							1 🗌 Yes 2	TN0				
	th with the 23a or 28	al Directo	10e. Street and Number 3114 Gracefiel	d Road, Wa	lden Ct.,#1	01 10f. Zip	Code 904					zen of Whated St							
936	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygjene, itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic avent, the Madical Examinar must be rotified at	by Funeral	11. Marital Status  1 Never Married 2 Mar  3 Widowed 4 Divorced	ied Armed For	dent Ever in U.S. ces? 2 XNo e attes:	3. Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		14. Race - Black, Specify:	America White, e	tc.					
Maryland 21215-0036	within 72 ho ane. than "natur ne Medical I	Completed		t's Education st grade completed)  College (1	-4or 5+) (G	cedent's Usua ive kind of wor e. DO NOT us	il Occupa k done d e retired)	ition uring most	of workii	ng		nd of Busir							
d 2	illed Hygie other	0	17. Father's Name (First, Middle,	Last)	Secr	etary		18. Mothe	r's Name	(First, Middle,			Gov	ernment					
ylar	should be nd Mental marked c	To B	Lawrence		Roche			Eve						okken					
Mar	and 2 shu Balth and m 27 is m		19a. Informant's Name/Relations Norman F. McCene		d 311	ailing Address 4 Grace	(Street a	nd Numbe Ld Roa	rorRuma ad, I	Nalden	ct.,	r Town, Sta #101	ste, Zip (	ode)209( ver Spr	)4 ingM				
Baltimore,	ages 1 are to th		20a. Method of Disposition  1  Burial 2  Cremation  4  Donation 5  Other (S		20b. Place of Dis	sposition (Namerematory or of	ne of ther place	)	D	ate	20c. Lo	cation - Cit	y or Tow	m, State					
Baltir	permit. Pages 1 Department of H Important: If its any injury or ot		21. Signature of Funeral Service		en wett	22. Name and Dona I.d 4400 Pc	d Addres	s of Facility Sorgwa	ardt	Funera ad Belt	1 Ho	me, I	PA	ATTAINI	.a 205				
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Meta Due to (c)  b. Due to (c)	used the death. Do not continue the line.  Astatic Carc or as a consequence of):  or as a consequence of):	enter the mode	e of dying	, such as	cardiac o	r respirat <i>o</i> ry ar	rest,			Approximate interval Betwer Dnset and Dea	en				
.O. Box 68760,	the death cartificate be executed the attending physician and sched for use as the burial-transit	Physician/Medical Ex	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	ent at time of death	3 □Ectopic pre					2	3d. Date o		/ Vay Yea	ır				
Δ.	es that igned b	by	Part II. Other significant condition	ons contributing to de	ath but not resulting in the	underlying ca	ause give	n in Part I.		127	obacco u	_		cause of deat					
of Vital Records,	The law requires ate has been sign page 2 should be	Completed	ompleted	ompleted	completed	Completed								24a. Was	an	24b. Wer	e autops	sy findings ava	ilable
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case relerred to medica examiner?	Hospital:						(Check only o	ne)								
ion of	ding Phys .r. After this funeral dia	ation; To	1 Yes No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Date o	patient 2 ER/Outpat f Injury a, Day Year)  28b. Time Injury	of 28	Bc. Injury Work	at	2	ne 5 X Resid 8d. Describe h			Specify)						
~	or At fter o Nreci	Certification;	3 ☐ Sulcide 6 ☐ Could a determined	ined 286. Place	of Injury - At home, farm, g, etc. <i>(Specify)</i>	street, factory,	office		2	8f. Location (S City or Tow	itreet and m, State)	d Number o	or Rural i	Route Number	,				
	To the Hospital or At within 24 hours after d To tha Funaral Direct completely filled in by	edical (	29a. Certifier Check only one) Certifying 2 Medical	g Physician: To the Examiner: On the ba and mann	best of my knowledge, de sis of examination and/or er stated.	ath occurred a investigation,	at the time in my opi	e, date and inion, deat	place, a h <i>o</i> ccurre	nd due to the o	cause(s) date and	and manne place, and	er as stat due to t	ed. he cause(s)					
)	To the within To the comp	Me	29b. Signature and title of certifie	John 50	Moult )	4.1	License D2364			-		signed (A		y, Year) , 2006					
	8		30. Name and address of person John H. Stuckey	M.D. 311	of death (Nom 23a) (Typ O Gracefiel	e, Print) d Road	Silv	ver S	prin	g, Mary	/lanc	1 2090	)4						
:	Sta Registr	-	31. Date liled (Month, Day, Year)  JAN 3	1 2006 <sup>32. Re</sup>	istrar's Signature	foods	,												

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Alphonso Jerome Nelson January 28, 2006 **Physician** 030 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Sandy Spring Montgomery Brooke Grove Nursing Home If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 15, 1928 7. Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number Funeral Days Months 1**⊠**M 2□ F Maryland Yrs. 77 217-20-0989 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ XIo Silver Spring Montgomery Maryland Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 20906 USA 3308 Beret Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status e filed within 72 hours efter al Hygiene "natural", or ite 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Black Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: \$ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education
(Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Abbott Laboratories Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 12 should be fill and Mental H is marked oth Juanita V. Mandy Alphonso Jerome Nelson permit. Pages 1 and 2 sh.
Depertment of Health and Important: if item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3308 Beret Lane, Silver Spring, Maryland 20906 Emma Lee Nelson/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Feb. 3 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery Silver Spring, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility. Francis J. Collins Funeral Home Inc 500 University Blvd, W, Silver Spring, MD 20901 ames 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final /Medical NON- HODGKIN'S CYMPHOMA 4 MONTHS disease or condition resulting in death) Examiner Due to (or as a consequence of): Examine signed by the attending physician and department of be detached for use as the buriel-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No \$ 24b. Were autopsy findings available prior to completion of cause of death? cate has been sig 24a. Was an autopsy performed? Completed The law 1 Yus 2 XNo 1 L Yes 2L No i or Attending Physicien: of terminal of the death.
Director: After this certifications. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes \_ 2 😿 No filled in by the funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide e Hospitai o 24 hours e e Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai completely (Check only one) To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle 3370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 WILLIAMSPORT E. MASITSA ST HOWE 15 N IED

State Registrar Year)

2006

32. Registrar's Signature

Corele

2000		1 - For State Registrar	State of Mary		artmer rtifica				Reg. N	.000	04216	
3,74	1. Decedent's Name (First, Middle, Last)  Physician  Rose Marie Pitcher								te of Death onth nuary 3	0 2006 ar	3. Time of Death 8:15A M	
/Medi Examir		4a. Facility Name (If not institution, give s	treet and number)		,		Location of De		4	c. County of Death	1	
		4905 Broomes Island Road Port Republic  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date							te of Birth	Calvert 9 Birth	place (State or Foreign	
Funeral Director			<sup>1M 2</sup>	Yrs.	Months		Hours Mi	Feb.	6 193	7 Mar	yland	
and w		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	ocation		w -d) +				10d. Inside City Limits	
Maryl 9-f sho	tor	Maryland Calvert		Port F	Repub.	lic					1 ☐ Yes 2 🖁 No	
ith the or 28c	Funeral Director	10e. Street and Number			10f. Zi	p Code				Citizen of What Cou	,	
e 23a	erail	4905 Broomes Islan	d Road  12. Was Decedent Ever	in 11 S 12	Mac Dass	206		(Cassify V		ited Stat		
ire, Maryland 21215-0036 s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 le marked other than "natural", or Iteme 23s or 28e-f show other traumatic event, the Madical Exeminer must be notified at	by	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No ff Yes, Give Year or Dates:		If Yes, spe		spanic Origin? n, Mexican, Pui Specify:	erto Rican,	etc.)	Black, White		
Maryland 21215-0036 nd 2 should be filed within 72 hours aft th and Mental Hygiene. 27 Is marked other than "natural", or traumatic event, the Madical Exam	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ducation de completed)  College (1-4or 5+)			edent's Usual Occupation e kind of work done during most of working DO NOT use retired)			C	16b. Kind of Business/Industry Calvert Count		
nd 2121 e filed within al Hygiene. I other than vent, the Ma		12 17. Father's Name (First, Middle, Last)		Depu	ity T	reasu		lama (First	Middle, Maide	overnmen	C .	
ylanc ould be f Mental H mrked of	To Be	Virgil Rawlings					Pearl		TVIIGGIO, TVIAIGO	on Samane)		
larylan 2 should be and Mental 1e marked surmatic ev	-	19a. Informant's Name/Relationship (Ty	ре, Print)	19b. Maili	ing Addres	s (Street a	ind Number or	Rural Route	e Number, City	or Town, State, Z	ip Code)	
e, N l and 3 lealth im 27 lher tr		C.W. Dickie Pitche			4905 Broomes Is. Rd.					ublic Maryland 20676 20c. Location - City or Town, State		
Baltimore, Misper and 2 permit. Pages 1 and 2 Department of Health important: If item 27 is any injury or other tractice.		1 □ ABurial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State	cernetery, cre	matory or	other place	Teb 2 2	2006			Maryland	
mit. P partme partme sorten / injur.		21. Signature of Funeral Service License					s of Facility			ral Home	-	
Dermi Depa Impo		Dimoci		44	405 В	roome	s Is. I				ryland 2067	
Physician /Medical Examiner	Examiner	resulting in death)	Due to (or as a co	nsequence of):	_			alnuti	rition		Onset and Death	
BOX 68760, eath certificate be executed ettending physician and for use as the burial-transit	dical Exa	resulting in death) Last	Due to (or as a co	nsequence of):								
. 5 65	Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetaf death 3[	□Ectopic pregnancy □ Other (specify)					23d. Date of delined Month	very Day Year	
S, P es that gned b	by P	Part II. Other significant conditions cor	tributing to death but no	ot resulting in the u	underlying	causa give	n in Part I.	23			the cause of death?	
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The lay	Completed	previous Pulmonary	Embolis					-	fa. Was an autopsy performed? ☐ Yes 2 1	prior to c death?	topsy findings available ompletion of cause of 2 No	
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25		30. Name and eddress of person who co				or Di	177d C111	ito 2	العدال ١٧	irk Mar.	land 20754	
Sta	ate	Jonathan Lowentha  31. Date filed (Month, Day, Year) FEB -	32. Registras				LVU. DU.	ice Z	חוווע בּיט	TEN PALY	Lanu 20754	

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21. Signatured Forgers Service Hooks age and Address of Facility  RAUSCH Funeral Home, P.A., Owings, MD 20736  23a. Part Letter the disease, or complicational that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate Cause (Final disease or condition)  Approximate Inferval Beneven Christ and Death (Inferval Beneven			•	Removal from State	cemetery, cr	ematory or other	place)				
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23a. Part I. Piter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  Approximate common the control of the cont	ny in		21. Signature of Funeral Service Licens	900							22726
Sicilan redical survey of the failure. List only one cause on each line.  Interval Beween Christ and Death Redical Interval Survey of Control on Condition on Con	E # 3		William 5	· Cros		Rausch I	uneral Ho	ome, P.A.	, Owing	s, MD	20736
FEMALE: 23b. Was decedent pregnant in the past 12 mognifs?   1 love brith 2   Fetal death 9 love of the people o	edical iminer	ai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a	a consequence of):  Aire was a consequence of):  a consequence of):	112	0, 24~				
FFMALE   236. Was decedent pregnant   1	the t	50		d	1 12						
1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   3   Probably   4   Making a valid   1   Yes   2   No   4   Making a valid   1	attending for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	1☐Live birth 4☐Pregnant at	2 Fetal death 3						•
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24a. Was an autopsy findings available prior to completion of cause death?  25. Was case referred to medical examiner?  1   Yes   2   Monte of Death   Check only one)  26. Place of Death (Check only one)  27. Manner of Death   Dea	E 9	5	- 1			,,		1.	Yes 2□No	3 ☐ Proba	ably 4 Wunknown
The part of the pa	houl	e									
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrates Signature	e fur	tie		(111011111, 154)	injury						
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dhysen  State  31. Date filed (Month, Day, Year)  32. Registrate Signature  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of the cause(s) and manner as stated.  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number  29d. Date signed (Month, Day, Year)  31. Date filed (Month, Day, Year)  32. Registrate Signature	al Director	Sertifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injubulding, etc.	rry - At home, farm, s :. (Specify)	treet, factory, off	ice	28f. Location City or To	(Street and Num wn, State)	ber or Rural	Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Thise State 110, +105PRD Print: Fred MD 20678  State 31. Date filed (Month, Day, Year) 32. Registrates Signature	e Funera detely fille		(Check only 2 Medical Exam	iner: On the basis of	examination and/or	ath occurred at the investigation, in r	e time, date and pla ny opinion, death oc	ce, and due to the curred at the time	cause(s) and m date and place,	anner as sta , and due to	ated. the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dhiren State 110, +105PRD Print: Fred MD 20678  State 31. Date filed (Month, Day, Year)  32. Registrate Signature	To the	Ž	29b. Signature and title of certifier			29c. Lic	ense number				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dhiren State 110, +105P RD Print Fred MB 20678  State 31. Date filed (Month, Day, Year)  32. Registrate Signature			D Shel	ND			50290		1-5	3 - 6	06
			30. Name and address of person who c	ompleted cause of de			Prince	Fred	MD	206	>8
Registrar JAN 3 7 2006 Magaza & Agraella &						-					

		1 - For Stete Registrar	State of Mar	yland / D	epartment of I	Health and M	Mental Hyg	_	ns.	04218
Physici.	an	Decedent's Name (First, Middle, Las	")				2. Date of Dea Month	ith Day	Year	3. Time of Death
/Medic			le Worth R	eeves,	Jr.		February		2006	14:45 PM
Examin	ier	4a. Facility Name (If not institution, give				or Location of Death	·		y of Death	
	ш		f Cecil					Cec		
Funeral Director		5. Social Security Number 6. Security Number 216-44-1971  Usual Residence of Decedent	7. Age (1 M 2 ☐ F 60	In yrs. last birth Y	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day FEB 21,	r. Year)	Coun	lace (State or Foreign try) 1 y 1 and
land ow		10a. State 10b. County	1	0c. City, Town	or Location				1	0d. Inside City Limits
should be filed within 72 hours atter death with the Maryland and Mentylene. Ind Mental bygiene. Ind Mental bygiene. Individed other than "natural", or Itams 23e or 28e-f show umatic evant. The Medical Examither institutional incitified at	ţ	Maryland Cecil		E1ktc	n					1 XYes 2 □ No
r 28e	Director	10e. Street and Number			10f. Zip Code		1	l0g. Citizen of	What Coun	itry?
h wit	a D	213 Hollingswort	h Manor		21921			Unit	ed Sta	ates
dea	Funeral	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Decedent of I	Hispanic Origin? (Sp	pecify Yes or No-	14. Ra	ce - Americ	an Indian,
atter or Ite		1 Never Married 2 Married	1 Tes 2 No		1 ☐ Yes 2 🌠 No		Hican, etc.)	Ì	ick, White,	etc.
ural',	d by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:		10 103 2 <u>A</u> 2140	эрвспу.		Speci	Wh:	ite
72 h "natu	Completed	15. Decedent's Ed (Specify only highest grad		(	Decedent's Usual Occup Give kind of work done	during most of work	king	16b. Kind of E		•
vithin ne. han '	щ	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT use retire	d)		Resid		
iled v dygie har t nt, to		12 17. Father's Name (First, Middle, Last)		Не	avy Equipmo	-		Const		)II
htal Hed of	Be					18. Mother's Nam		Maiden Sumai	me)	
1 Mer 1 Mer nark	<sup>L</sup>	Orville Worth Re				Anna S	<u> </u>			
12 st hand 7 Ian rraun		19a. Informant's Name/Relationship (T			Mailing Address (Street					Code)
1 and Healt am 2 thar		Vicki A. Davenpo			Maple Cou: Disposition (Name of	rt, Elkto				
permit. Pages 1 and 2 should be filed within 72 hours. Department of Health and Mental Hyghene. Important: If item 27 is marked other than "natural", of any injury or other traumatic event, the Modical Expone.		1 X Burial 2 ☐ Cremation 3 ☐ I	Removal from State	Cherry	crematory or other pla		uary 9,	20c. Location	- City or 10	wn, State
t. Partmer		`4 □ Donation 5 □ Other (Specify,		Method	ist Cemeter	cy 200			Hill,	Maryland
Depa mpo mpo iny ir		21. Signature of Funeral Service Licens	, / ,		Hicks Home	es of Facility For Fune	erals, P	.A.		
40 = 4 G		- Donied -	. Aluka	ر	103 W. Sto	ockton Sti	reet, Ell	kton, N	Maryla	
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	ne cause on each line.							Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)	a. Adult 1	Sespite	tony Dastr	or Syyd	rone			رره له الم
/Medical Examiner		Toodking in dodiny	Due to (or as a c	onsequence of	tony Date			-		
F115	<u>.</u>	Sequentially list conditions,	b. TSPICA	Tion 1	ne undary	10d 1	14 e v u q	4.9		7 801
ted nsit	Examiner	cause. Enter Underlying Cause (Disease or injury	500 13 (51 43 4 5	on acquentee or	<i>j-</i>					
xecu al-tra	хаг	that initiated events resulting in death) Last	c. Due to (or as a co	onsequence of	):					
rate be executed hysician and the burial-transit	icai E									
ticate phy: s the	edic		o							
eath certitic attending p	/W	IF FEMALE:	23c. If yes, outcome of p	pregnancy				224 Da	to of doline	
atter I for u	Physician/M	in the past 12 months?	1 Live birth 2 C 4 Pregnant at tim	Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	+			ite of deliver onth	Day Year
the d y the iched	iysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9☐Unknown	0. 000	o a out of (specify)					
ires that the de signed by the a I be detached t		Part II. Other significant conditions co	ntributing to death but n	ot resulting in t	he underlying cause giv	en in Part I.	23e. Did tob	oacco use con	tribute to the	e cause of death?
uires 1 sign 1d be	d b	Acute and c	Granic 110	er t	eilure		1 □ Ye	s 2 🗆 No	3 Proba	ably 4 Unknown
w require been sig should b	Completed by	Acute and c	1.	. /	• / • '		24a. Was a	245	Mora auton	an finding qualible
ne lav s has ge 2	E .	151 ( O WO ITC NE	PATITU	444 6	1074650		autops	v		sy findings available apletion of cause of
n: Th ticate rr, pa		OF West and a standard to the district					perform	/	1 🗆 Yes	2 No
certil	o Be	25. Was case referred to medical examiner?	Hospital:		— Oth	26. Place of Death				
Phy r this ral di	-	1 Yes 2 140	1 Impatient 28a. ate of Injury	2 ER/Outp	ne of 28c Injur	er: 4 ☐ Nursing Ho	me 5 Reside 28d. Describe ho			)
ding h. Afte tune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation	(Month, Day Ye	ear) Inji	ury Wor	k? Yes 2 □ No	200. 2000,120 110	W mijury occur	160	
Atten deal ctor: y the	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury	- At home, farm	n, street, factory, office		28f. Location (St	reet and Numi	er or Rural	Route Number
atter Dira	Certification:	4 Homicide	building, etc. (8	Specify)			City or Town			, 10 010 110 110 110 110
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attedeath. with the Funnerial Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier (Check only one) 2 Medical Exami	sician: To the best of m ner: On the basis of exi and manner stated	amination and/	death occurred at the tir or investigation, in my o	ne, date and place, pinion, death occurr	and due to the cared at the time, da	ause(s) and mate and place,	anner as sta and due to	ated. the cause(s)
o the	Me	29b. Signature and title of certifier	1	-	29c. Licens	e number	29	9d. Date signe	d (Month. F	Day, Year)
P 3 ⊢ δ		Mull . 1.								
		30 Name and address of access into	- moleted source of dear	/Itom as: \ C	ype. Print)  + os p. + a ( ,	1170	1	CUYUM	ره م	AUDO
0		30. Name and address of person who co	IMM (1	(Item 23a) (T	ype, Pnnt)	106 R.	C+ C	11/2-	11.	n 71971
Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's	Signature.	10> (11)	100 000	)T, C	NTOU	, 091	0 6176
Sia Registr:		FEB 1 4 2	006	1 19	March !					

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		-	For State Registrar	State of M	Maryland /	-	artmen <i>rtificat</i>			and M	lental Hygi	ene g.No.00	6	14219
	ysicia	n	Decedent's Name (First, Middle, La		raine G	. Re	id				2. Date of Death Month Januar	Day	2006	3. Time of Death 11:40 A M
	fledica amine		4a. Facility Name (If not institution, giv Anne A	e street and numbe Arundel Medic			4b. City,	Town, or	Location of	of Death Anna			y of Death Anne A	
Fun Dire	eral ctor		5. Social Security Number 220-66-9212 6. S	ex	Age (In yrs. last 48	birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month Dev)	<sup>Y</sup> 1957	9. Birthp Cour	lace (State or Foreign Maryland
Maryland -f ahow	fied at		Usual Residence of Decedent  10a. State 10b. County  Maryland Anne	Arundel	10c. City, To	own or Lo	ocation	L	othian				1	0d. Inside City Limits X 1 ☐ Yes 2 ☐ No
with the	Toe not	Director	10e. Street and Number 6123 McKendree Road				10f. Zip	Code	207	11	10	g. Citizen of	What Cour U.S./	
U KIKISTOUGGO  filed within 72 hours after death with the Maryland Hygiene.  then **Inatural**, or Items 23a or 28a-f ahow	Exactinar mus	by Fur	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceder Armed Force: 1  Yes 2 If Yes, Give Year or Dates	No.		Was Deced If Yes, special		spanic Ori n, Mexicar Specify:	gin? (Spe i, Puerto	acify Yes or No- Rican, etc.)		ce - Americ ick, White, fy:	
within 72 hc ene.	ne Medical	Completed	15. Decedent's E (Specify only highest grades) Elementary/Secondary (0-12)	ducation ide completed) College (1-40		Sa. Dece (Give life.	dent's Usua kind of wo DO NOT u	al Occupa rk done d se retired Distric	ation furing mos t Mana	t of worki ger	ng	6b. Kind of E	Jusiness/Ind Thrift S	
hould be filed within Mental Hygiene.	2	To Be Co	17. Father's Name (First, Middle, Last, Stanley N	/I. Rawlings					18. Mothe	er's Name	e (First, Middle, M Zel	laiden Sumai <b>ma Wil</b> ls	me) S	
and 2 shortally and health and h	er treuma		19a. Informant's Name/Relationship ( Lindsey Reid, Jr. Husb	Type, Print) and	1	9b. Maili P	ng Address .O. Box	(Street a	ind Numbe thian, I	or or Rura <b>Maryla</b> :	nd 20711	City or Town	, State, Zip	Code)
Dallillore, Dermit. Pages 1 a Department of Hez Important: If Item	ury or oth		20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif		te 20b. Place ceme	tery, cre.	osition (Nar matory or d ine Jon	ther plac	e) netery		02/01/06	Oc. Location Chesa		wn, State Beach, MD
permit. Pag Department Important:	eny inj		21. Signature of Funeral Service Licer	Surell	0	2:	2. Name S	ewell 1	uneral ures Be	Home ach R	oad Prince f	rederick	, MD 20	678
Physic /Med Exami	ical ner	er	23a. Part1. Enter the sease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	aDue to (or a	as a consequence as a consequence	3P1 :0 of): +R1	RAT		y Y ER	FF	or respiratory arred HILURE DISEA	=		Approximate Interval Between Onset and Death
the Hospital or Attending Physician: The law requires that the death certificate be executed nin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and	ing et	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	-	PERT as a consequence EAST	ce of):	VSIC CAN		R					S
r.O. box oc requires that the death certifica been signed by the attending ph	ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Onknown		2 Fetal dea		⊒Ectopic pi ∃ Other (sp						ate of delive	ery Day Year
w requires that	uld be det	Š	Part II. Other significant conditions of	ontributing to death	but not resulting	g in the u	inderlying o	ause give	an in Part I			acco use con s 2 🗆 No	_	ne cause of death?
aician: The law re	age 2	Completed									24a. Was an autopsy perform	ed?	prior to condeath?	psy findings available mpletion of cause of
OI VICAL Phyaician: This certifical	ector,	Be	25. Was case referred to medical examiner?	Hospital:				Othe	NE:		Check only one			
ding Phys	funeral d	tlon: To	1  res 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Ir (Month, L		Outpatie Time of Injury		8c. Injun	4 🗆 140	1	me 5 Resider 28d. Describe hor			y)
al or Attendi after death.	d in by the	Certification:	3 Suicide 6 Could not b	e 28e. Place of	Injury - At home, etc. (Specify)	farm, st	reet, factor	, office			28f. Location (Str. City or Town,		ber or Rura	l Route Number,
LIVISION To the Hospital or Attentivitin 24 hours after deall To the Funeral Director:	completely filled in by the	edical	29a. Certifier 1 Certifying Pt (Check only one) 1 Medical Example 1	ysician: To the be- niner: On the basis and manner	of examination	ige, deat and/or in	h occurred vestigation	at the tim , in my of	e, date an pinion, dea	d place, a	and due to the ca ed at the time, da	use(s) and m te and place,	anner as si and due to	tated, the cause(s)
To th within	com		29b. Signature and fittle of certifier	zen	_		Ė	DY	number	59		d. Date signe	- 30	0-06
3	0.		30. Name and address of person who LIPISHREE 31. Date filed (Month, Day, Year)	mpleted cause of	f death (Item 23) A Stragg Signature	a) (Type,	Print)	LAR	VDOV	ER	ROAD,	CHEV	ERLY	, MD - 2078
Re	State gistra	r	JAN 3	1 2006	Alessa 1	K	Gos	West.	£1					

DHMH 17 Rev 1/2001

		•	For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of F		, ,	iene	5 0	4220
	500	1	Decedent's Name (First, Middle,	Last)				2. Date of Deat			3. Time of Death
10°	Physicia	an	Edna	Leona	Robert	son		January	<sup>Day</sup> 27, 2	99ar 006	5:45 p M
	/Medic Examin	1000	4a. Fecility Name (If not institution,		1102020		or Location of Dea		4c. Count		J. 13 P
	LXaIIIII	C1	6740 Briscoe Tu	ırn Road		Owin	as		Ca	lvert	_
	Funeral			. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	7				place (State or Foreign
	Director		215-26-2916	1□M 2X F 73	Yrs.	Months Days	Hours Will	June 1,	1932		land
	p ,		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	estion					I Od. Inside City Limits
	anyla show	7	,		Too. Oily, Town of Lo						1 ☐ Yes 2 XNo
	Ba-1	Director	MD Calver	t		Owin	ıgs		O- Citi of	14/h - 4 C	
	with t	급	10e. Street and Number	I		10f. Zip Code		1	0g. Citizen of		nuy:
	e 23	Funeral	6740 Briscoe Tur	n Road 12. Was Decedent E	ver in IIS 13	2073		Specify Yes or No-	US 14 Ba	ce - Americ	can Indian
	Itam Inarr	Ę,	11. Maritaf Status  1 □ Never Married 2 □ Marrie	Armed Forces?		If Yes, specify Cub	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ick, White,	
99	al', or	by	3 ☐ Widowed 4 🎇 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2XX No	Specify:		Specii	<sup>fy:</sup> whi	ite
Ģ	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or Itame 23a or 28a-f show snt, tra Medical Examinar must be notified at	ted	15. Decedent's			dent's Usuaf Occup		action of	16b. Kind of B	Business/In	dustry
215	thin 7	ple	(Specify only highest Elementary/Secondary (0-12)	Coflege (1-4or 5-	life.	DO NOT use retire	d)	n King			
2	er th	Completed	7		deli	.catessen			grocer		ore
pu	be file	Be	17. Father's Name (First, Middle, La					me (First, Middle, i			1
yla	Men Men arke	မ	Thomas Merle	Cochran			Wilhel			Bevei	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If itsm 27 is marked other than "natural", or Itsme 23a or 28a-1 show any Injury or other traumatic svent, the Medical Examinat must be notified at once.		19a. Informant's Name/Relationshi					lural Route Number			
	tealth		Thomas C. Robert 20a. Method of Disposition	son, son	2199 20b. Place of Dispo		itine ct.	, Great N	20c. Location		20634
Baltimore,	ges if of h		1 X Burial 2 ☐ Cremation 3		cemetery, crei	matory or other pla	· 1			•	own, State
ţ	t. Pa rtmer rtant:		4 Donation 5 Other (Spe		Mt. Harm	Ony Ceme:  2. Name and Addre		31-2006	Owings	, MD	
Bal	Depa Impo Iny Ir		21. Signature of Funeral Service Li	Carlsee Car			·	me, P.A.	Owino	rc MT	20736
100	No.		23a, Part1. Enter the disease, or c	omplications that caused						15, II	Approximate
		g s	shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line	1.	1.0		_			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	7	1/2	ATT I	F4, lun	e	- 4	
	Examiner			Due to (or as	consequence of):						
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						
	uted d ansit	Examine	Cause. Enter Underlying Cause (Disease or injury that initiated events								
Ć.	exec an an rial-tr		resulting in death) Last	Due to (or as a	consequence of):						
8760,	cate be executed physicien and the burial-transit	dicai		d	<del></del>						
9	ntifica ng ph as th	Med	IC COUNTY								
Вох	death certific e attending p id for use as	an/l	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth		∃Ectopic pregnand	·y			ate of deliv	ery Day Year
	e dea he at hed fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown	ime of death 5	Other (specify)			IVI	Ontil	Day Toal
P.0	that the de led by the a detached	Phy	9 Unknown				una in David I	220 Did to	bassa usa san	stributo to t	he cause of death?
	9 P. P. P. P. P. P. P. P. P. P. P. P. P.	þ	Part II. Other significant condition	s contributing to death bu	t not resulting in the u	inderlying cause gi	ven in Fait i.	1 🗆 Y		3 ☐ Proi	
oro	w requir	Completed									
Sec.	8 6	npi m						24a. Was a autops	sy	were auto prior to co death?	opsy findings available impletion of cause of
=======================================		S							2 No	1 ☐ Yes	2 □ No
Vital Records,	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		Ot	her	eath (Check only or			
o	Phys this ral di	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatier	<del></del>	II JU DOA	4   Nursing	Home 5 X Reside			fy)
no	ding P. h. After funera	tlon	17€€Natural 5 ☐ Pending	(Month, Day	Year) Injury	Wo	ork? ]Yes 2∐No		,,		
Division	il or Attending after death. I Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could no	t be 28e. Place of fnju	ry - At home, farm, st	reet, factory, office				ber or Run	al Route Number,
Ö	after after Dire	Certification:	4  Homicide determin	building, etc	. (Specify)			City or Tow	n, State)		
	Hospital 24 hours a Funerel I stely filled		29a. Certifier Certifying	Physician: To the best o	f my knowledge, deat	h occurred at the t	ime, date and place	e, and due to the c	ause(s) and m	nanner as s	stated.
	To the Hospital or Attenwithin 24 hours after deall To the Funerel Director: completely filled in by the	Medical	(Check only 2 Medical E	xaminer: On the basis of and manner state	examination and/or in	ivestigation, in my	opinion, death occ	curred at the time, d	late and place	, and due t	o the cause(s)
	To the I within 2. To the I complet	Ž	29b. Signature and title of certifier	101	1-	29c. Licen	se number	2	29d. Date sign	ed (Month,	Day, Year)
}			1029	N/00	MI	7	305221	12	0//	30/	2006
	•		30. Name and address of person w	,.							
	IU		J. Barth, M.D.		pital Rd.,	Ste. 31	0, Princ	e Frederi	ick, MD	206	578
	Sta Registr		31. Date filed (Month, Day, Year)	3 1 2006	s Signature	hours !	ý				

			1 - State of Mary Registrar		nt of Health and I te of Death	Mental Hygiei	4000	04221
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death		3. Time of Death
	Physici /Medic		Stanley W.	Robinson		January :	28,2006	9:15P™
P	Examin	er	4a. Facility Name (If not institution, give street and number)  Charlotte Hall Veteran:		y, Town, or Location of Death ${\tt narlotte}$ Ha		4c. County of Deatl	
	Funeral						St. Ma	nplace (State or Foreign
	Director		217-24-2899 X M 2 F 74	Months	Days Hours Min.	8. Date of Birth (Month, Day, Ye cember 2	9,1931 co	Unknown
	pug 🗼		Usual Residence of Decedent           10a. State         10b. County         10c	. City, Town or Location				
	Maryla f eho	ō						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	28a-	Director	MD St. Mary's	Charlott	LE HALL	100.	Citizen of What Cor	Λ
	after death with the Maryland or Iteme 23a or 28a-f ehow colling most be rediffed at	al D	29449 Charlotte Hall Roa	ad	20622		USA	,-
	eme.	Funeral	11. Marital Status 12. Was Decedent Ever Amed Forces?	in U.S. 13. Was Decr	edent of Hispanic Origin? (S ecify Cuban, Mexican, Puert	pecify Yes or No-	14. Race - Amer Black, White	
9	hours after tural', or ite	by Fu	1 X Never Married 2 Married 1 Yes 2 No	1 □ Yes		o Thour, sto.)	1	31ack
21215-0036	ture!		3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education	16a. Decedent's Usi	ual Occupation	16h	Kind of Business/I	
212	within 72 ene. than "nai	Completed	(Specify only highest grade completed)	(Give kind of w	vork done during most of work use retired)	rking	. Killa of Basillessyl	ndustry
		Com	Elementary/Secondary (0-12) College (1-4or 5+)	unkno	wn		unkn	iown
Maryland	be filed Ital Hygi od other event, I	Be	17. Father's Name (First, Middle, Last)		18. Mother's Nam	ne (First, Middle, Maid	len Sumame)	
2	should nd Men i marke umatic	٦	unknown 19a. Informant's Name/Relationship (Type, Print)			nknown		
Z	122 7 148		Julie Van Orden/Guardian	P.O. Bo	ss (Street and Number or Ru Ox 653, Leo	<sup>ıral Route</sup> Number, Cit nardtown	y or Town, State, Z MD 2065	ip Code) 50
ē,	s 1 and f Healt ltem 2 other		20a. Method of Disposition 20	b. Place of Disposition (Na	ame of	and the same of th	Location - City or 1	
altimore,	90=5		1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery, crematory`or insfield-E	Echols 1/31		rlotte H	
ॿ	permit. Pag Department Important: any Injury o		21. Signature of Fungral Service Licenses MO14	0.0	TARTSECHOLS			
<u>n</u>	80 = 9		Variet T. Libert . /2	P.O.	BOX 567.	LA PLATA		
			23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	leath. Do not enter the mo	de of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Deme	ntia -1	1ascular			Onset and Death
	/Medical Examiner		Due to (or as a cor	1	1			1000
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	sequence of):	raar			1775
	d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	extensio	Λ.			1995
Ď,	e exection and arrial-tr	Exa	resulting in death) Last Due to (er all con		15			101-
2/PU	cate be executed physicien and the burial-transit	dlcal	d. Bacte	remia,	/Sepsis			1/3/2006
×	certific nding p	/Me	IF FEMALE: 23c. If yes, outcome of pre	annanov				
X D	death	clan	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 4 Pregnant at time	etal death 3 Ectopic p			23d. Date of delive Month	∕ery Day Year
j.	t the c by the achec	Physician/Me	9 □ Unknown 9 □ Unknown					
ις. L	w requires that the death certifii been signed by the ettending p should be detached for use as	by P	Part II. Other significant conditions contributing to death but not	resulting in the underlying	cause given in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
SDJC	sen si	ted	Cerebrovascular ac	cident		1 ☐ Yes	2□No 3□Pro	babiy 4 Stinknown
ecor	The law rate has be	Completed by	Anemia			24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
	ysicien: The lav is certificate has director, page 2			emonia		performed? 1 ☐ Yes 2 ☐	death?	
VII	Physicien: this certific ral director,	o Be	25. Was case referred to medical examiner?		104	th (Check only one)		
	Phys ar this aral dir	$\vdash$	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Inpatient :  27. Manner of Death	2 ER/Outpatient 3 Do	OA 4 Ursing Ho 28c. Injury at Work?	ome 5 Residence		(fy)
5	Attending I or death. ector: After by the funer	atlo	1 Matural 5 Pending (Month, Day Yea 2 Accident investigation	r) Injury M	Work? 1 ∐ Yes 2 ∐ No			
JIVISION	r Atte	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp	At home, farm, street, factor	y, office	28f. Location (Street City or Town, Sta		al Route Number.
	oltal o urs afi oral Di							
	To the Hospital or Attending Ph Within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier   1   Certifying Physician: To the best of my (Check only one)   2   Medical Examiner: On the basis of exam and manner stated.	knowledge, death occurred nination and/or investigation	at the time, date and place, n, in my opinion, death occur	and due to the cause rred at the time, date a	(s) and manner as s ind place, and due t	stated. to the cause(s)
	ro the within ro the	Me	29b. Signature and title of certifier	29	c. License number	29d. D	Date signed (Month,	Day, Year)
	. , , ,		I Paul Atminin		145092	0	1/301	2006
()	No.		30. Name and address of person who completed cause of death (				10-1	
1	BIVA		110 tospital Roda		205, Pri	nce Fro	drick,	MU 2067
ľ	Stat Registra		31. Date filed (Monfh, Day, Year)  32. Pigistrar's Si	gnature Sparks	,		,	

State of Maryland / Department of Health and Mental Hygienen Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Year Feb 5, 2006 Smith 1122 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frostburg Frostburg Village Nursing Home Allegany If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday): 8. Date of Birth Oct 29, 1932 9. Birthplace (State or Foreign **Funeral №**□M 2□F Director 214-32-3747 73 Yrs. Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location ral', or items 23a or 28a-f ahow Examinar over be notified at 10d, Inside City Limits MD Allegany Cumberland Director M Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21502 220 Somerville Avenue Apt. 509 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married V□Yes 2□No IfYes, Give Korea Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No ģ 3 ☐ Widowed 4 ☐ Divorced Specify: white "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within 7 h and Menta! Hygiene. 7 is markad other than "n Elementary/Secondary (0-12) College (1-4or 5+) baker M&M Bake Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William J.B. Smith Nellie Hess Smith 19a. Informant's Name/Relationship (Type, Print)

daughter 19b. Mailing Address. (Street and Number or Rural Route Number, City or Town, State Zip Code) 26 Brian Drive Carlisle PA 17013 permit. Pages 1 and 2. Department of Health a Important: If Itam 27 is any injury or other trauonce. 20b. Place of Disposition (Name of 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State Scarpelli Funeral Home, PA 2/8/2006 MD Cresaptown 1 4 ☐ Donation 5 ☐ Other (Specify) 22. NarScatfielli Pune PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The taw requires that the death certificate be executed labare resulting in death) Last Due to (or as a consequence of): the attending physician a hed for use as the burial P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☑ No 4☐Pregnant at time of death Month Day Year 5 Other (specify) 9 Unknown 9 🗆 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, à pe 3 Probably Completed engestive 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has performed? Sterond certificate of Vital 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA ihis 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Division Hospital or Attanding 1 Natural 2 Accident s after dea. af Diractor: After 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeref L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D14464 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rostburg Village Nursing Home ndhip ) a 32. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 4 2006 Registrar

State of Maryland / Department of Health and Mental Hygiege Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** February 2006 5:08 p. Brian Lee Stottlemyer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Memorial Hospital Frederick Frederick | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 14,1973 Birthptace (State or Foreign Country)
 Mary Land 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 1 →M 2 □ F 32 214-84-6777 Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits froms 23a or 28a-f show 1 ☐ Yes 21 No Directo Frederick Mversville Maryland 10f. Zin Code 10g Citizen of What Country? 10e. Street and Number 4326 Middlepoint Road 21773 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ☐Yes 2 No f Yes, Give 1 X Never Married 2 ☐ Married The Medical Example ŏ 1 ☐ Yes 2 🖺 No Saltimore, Maryland 21215-0036 Specify. Specify: White ρ If Yes, Give "Year or Dates: 3 Widowed 4 Divorced natural Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Bindery Technician Board of Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stottlemyer George Lee Barbara Ann Mvers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Lee Stottlemyer/father 4326 Middlepoint Road, Myersville, MD 21773 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Salem U. Methodist 2-9-2006 Wolfsville, Maryland \* 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 504 Main Street Ricketts Funeral Home ath Myersville, MD 21773 23a. Part1. Enter the disease, at pumplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEIZURE DISCROER 28 years **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine physician and s the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 21 No has 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Pres 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA 2 this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 □ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D20488 2-6-06 30, Name and address of person who completed cause of death (Item 23a) (Type, Print) MIDDLETOWN, MD. 21769 Koessler mo PO BOX 20 ames L. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registres Certificate of Death Reg. No. 2. Date of Death Day Z6 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 454 M 2006 G. Simpson Jel w w ww Estella /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Colem mny Machial Baltimore Washington ( ent Pennig If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Year) Days Months Hours 1 M 200 78 223-30-4689 June 4,1927 Virginia Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h Count 10a State 28e-f show Examinist must be notified at 1 ☐ Yes 2√2No Directo Crownsville MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be fitted within 72 hours after death with Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "--- any injury or other treum-sit." 5 21032 USA Items 23a 1077 Plum Creek Drive by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Giant Food Cosmetician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frank Grimes Blanche Chambers ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1077 Plum Creek Drive, Crownsville, MD 21032 Patricia Bowers (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory 1-27-2006 Baltimore, MD A □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service disensee 22. Name and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ntracerebra Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physician and Due to (or as a consequence of): The law requires that the death certificate be Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 Tyes Hospitel or Attending Physicien: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA Certification: To 1 ☐ Yes 2 No 1 Dipatient 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1-Natural death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 24 hours after deatl Funerel Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier refacertifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 To the I 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30

Registrar

DHMH 17 Rev 1/2001

State

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egistrar's Signature

JAN 3 0 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** JANUARY 2006 Mary Catherine Shimer 10:50 p<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🕱 F Director 85 548-36-1751 Wisconsin Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other then "naturel", or items 23a or 28a-f show injury or other traumatic event, the Maidical Examinar must be notified at 1XXYes 2 ☐ No Director Maryland Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1668 Carlyle Drive Apt. 7-J 21114 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married ☐Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Medical Nurse permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny linjury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) Be ( 18. Mother's Name (First, Middle, Maiden Sumame) Cora Kubicek Louis Gregurich 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23203 Stewart Way McDaniel, MD 21647 Judith Warner/ Daughter 20b. Place of Disposition (Name of cometary, crematory or other place)
Lakemont
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/04/2006 Davidsonville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 16000 Annapolis Road Bowie, MD 20715 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHORESCUENTIC CAMMONASCUM MITTHE Physician YEARS /Medical Examiner CARATO MYOPATH Y. GARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and the burial-transit Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending ph IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death igned by the a be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Rart I. 23e. Did tobacco use contribute to the cause of death? δ KLW-MMY Whose 3 Probably 44 Unknown 1 ☐ Yes 2 ☐ No Be Completed HEART 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? 2□ No 1 Yes 212 No t TYes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? funeral director. 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Yeer) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending s after death. 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a To the Funeral C Legarifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and Arth of certifier DS6096 (rel 1-26-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RAJBINDER S GILL SHAH ASSOC HOLLYWOOD MD 32. Registrar's Signature 20636 31. Date filed (Month, Day, Year) State JAN 3 0 2006 Registrar

SHIMER

CATHERINE

MARY

			1 - For State Registrar	_	f Marylan	d / Depa		t of H	ealth a		lental Hy		06	0422	26
1.0	Physici	an	1. Decedent's Name (First, Middle, La								2. Date of De Month		Yea	3. Time of	
	/Medic		Robert Andrew San								January	-			Рм
	Examin	er	4a. Facility Name (If not institution, given Anne Arundel Medi			i		Town, or apo 1	Location o	of Death			County of D		
-	Funeral	<b>4.3</b>		Sex Sex	7. Age (in yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Bir	th			r Foreign
9	Director		146-24-2749 Usual Residence of Decedent	<b>Ж</b> М 2□ F	73	Yrs.	Months	Days	Hours	Min.	July 25	, 19	32 N	Birthplace (State of Country)  ew Jersey	У
	land ow		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside Cit	ty Limits
	Mary Fied	tor	Maryland Anne Ar	unde1		A	nnapo	lis						1 ∑ Yes	2 □ No
	or 28	Olrec	10e. Street and Number	15.61			10f. Zip					-	en of What	•	
	ath w	ral	6 Constitution Sq					401					ed St		
920	urs after de el', or Item	by Funeral Director	11. Marital Status  1 Never Married	12. Was Dec Armed Fo 1 D Yes If Aes, Gi Year or D	ve No 19.	55-	Was Deced If Yes, spec		spanic Ori n, Mexicar Specify:	gin? (Sp n, Puerto	ecify Yes or No Rican, etc.)		Black, W	merican Indian, hite, etc. Wh <b>ite</b>	
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is merked other than "netural", or Iteme 23a or 28e-f ehow or other traumatic event, the Markeal Examinat must be mailtied at	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (		16a. Dece (Give life.	kind of wor DO NOT us	rk done d se retired	urina mos	t of work	ing		d of Busine		ina
d 2	filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last	) 4		EII	ginee	L	18. Mothe	r's Nam	e (First, Middle,			Engineer	ing
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Baltimore,	t of He If item or oth	1	20a. Method of Disposition 1 ☐ Burial 2 🖔 Cremation 3 ☐	Removal from		Place of Disponentery, crem					Date			or Town, State	
Ē	permit. Pages I Department of H Important: If ite eny injury or ot once.		4 Donation 5 Other (Speci		Ват	timore					/2006			, Marylan	
Ba	Depa Impo eny i		21. Signature of Funeral Service Lice	Lan		1	47 Du	ke o	f G1c	uce	ster St	. Ann	apoli	s, MD 21	401
10			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on	caused the deat each line.	h. Do not ent	er the mod	e of dyin	g, such as	cardiac	or respiratory a	rrest,		Approximate Interval Bety Onset and D	ween
1	Physician /Medical		disease or condition resulting in death)	a. Due to	(or as a conseq	uence of):								nechs	
ź	Examiner	L.	Sequentially list conditions,	b. Due to											
	nsit	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events	Oue to	(or as a conseq	pence of									
o	ate be executed hysicien and he burial-transit		resulting in death) Last	c. Due to	(or as a conseq	uence of):									
8760,	ate be hysici the bu	lical		_ d				<u>-</u>							
P.O. Box 68	that the death certificat ed by the ettending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	1 ☐ Live I	itcome of pregna birth 2 ☐ Feta nant at time of d nown	death 3	Ectopic pr					2	3d. Date of Month		Year
	res that the igned by be detact	by Pr	Part II. Other significant conditions		- 1		nderlying c	ause give	n in Part I		23e. Did t	obacco u	se contribut	e to the cause of d	Jeath?
g	w require been sig should b		M46/09/201	aric.	syndro.	re					10	Yes 2,5	3No 3□	Probably 4 🗍	Jnknown
of Vital Records,	The la ate has page 2	Completed	Pancyt	openia							24a. Was auto perfo 1 \( \text{Yes} \)			autopsy findings a to completion of ca 1? Yes 22 No	
/ita	Physicien: ' this certifica al director, p	Be (	25. Was case referred to medical examiner?	Hospital:	-			100		of Dea	h (Check only o	опе)			
ot	Phys this ral dir	T.	1 Yes 2 No	28a. Date	Inpatient 2	ER/Outpatier 28b. Time o		A Othe	4 🗆 140	irsing He	ome 5 Resi 28d. Describe			Specify)	
0	Attending I r death. ector: After by the funer	tlon	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Mor	nth, Day Year)	Injury	м	Work	ດ?ີ່ Yes 2 🔲	No	200. 0000100		00001100		
Division	tel or Attendii s after death. al Director: A ed in by the fu	Certification;	3 Suicide 6 Could not l 4 Homicide determined	2.08. Place	e of Injury - At h ling, etc. (Special	ome, farm, sti fy)	reet, factory	, office			28f. Location ( City or To			r Rural Route Num	iber,
	Hospi 4 hour Funer ely fill	Medical C	29a. Certifier Certifying P (Check only one) 2 Medical Exa	miner: On the t	e best of my kno casis of examina oner stated.	owledge, deat ation and/or in	h occurred vestigation	at the tim	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(s) date and	and manne place, and	r as stated. due to the cause(s	s)
)	To the within 2 To the complet	M	29b. Signature and title of certifier	m,	W				s number	0/	# 300	29d. Date 191	signed (M	onth, Day, Year) 27, 200	3
		1	30. Name an address of person who	of N	17	900	Print)	7397	e R	J	# 300	An.	ngol.	5, MD 214	44
1000	Sta		31. Date filed (Mogth Day, Year) JAN 3 1 2	006 32	egistrar's Signa	ature								7 - 1	
DH	Registi		37,11 0 1 2	000	egistrar's Signa	K A	Sel.								

ORIGINAL

			For State Registrar		State of	f Marylar			nt of H		and M	ental Hy	gien Reg. N	211111	5	042	27
			1. Decedent's Name (First, M	iddle, Last	)							2. Date of D	eath			3. Time o	of Death
	Physici /Medic		JOHN		L		STI	LE	Y			Month O I	a d		90°	21:	35 PM
	Examir		4a. Facility Name (If not instit	ition, give	street and nun	nber) /3		4b. Cit	y, Town, or	Location o	of Death		40	C. County of	Death		-
			-PALTIMORE	VAM	led ica	Lle.	stell	134	Him	ore				NA			
	Funeral		5. Social Security Number	6. Se	M 2 F	7. Age (In yrs.	. last birthday) Yrs.	Month	er 1 Year s Days	If Under 2 Hours	Min.	8. Date of B (Month, D	ay, Year	)	Coun		or Foreign
	Director		225-66-4001 Usual Residence of Deceden			55						Oct.	$^{4}, 1^{6}$	950 L	lary	land	
	yland		10a. State 10b. Co	inty		10c. C	ity, Town or Lo	ocation							1	Od. Inside C	City Limits
	a-f s	ctor	WV Ber	keley	,	Bı	ınker H	Hill								1 🗌 Yes	s 2√2 No
	or 28	Director	10e. Street and Number						ip Code				10g. C	itizen of Wha	at Coun	itry?	
	eth w	ra l	2831 Giles	Mill					25413					US			
	er de	Funeral	11. Marital Status	W	12. Was Dece Armed For	rces?	J.S. 13.	Was Dec	edent of His ecify Cubar	spanic Orig n, Mexican	gin? (Spe i, Puerto l	cify Yes or N Rican, etc.)	lo-	14. Race - Black,	Americ White,		
36	rs aft	by F	1 ☐ Never Married 2 ☐ X X 3 ☐ Widowed 4 ☐ Divo		1 ▼ Yes If Yes, Giv Year or Da	e 1970 ates: 1970	0-72	1 🗆 Yes	2 X No	Specify:				Specify:	Whi	ito	
21215-0036	within 72 hours after deeth with the Maryland ene. than "natural", or iteme 23e or 28e-f ehow he Madigal Exeminer must be notified at	ted	15. Dece	dent's Edu	cation		16a. Dece	dent's Us	ual Occupa	tion			16b. i	Kind of Busin			
215	hin 7	Completed	(Specify only his Elementary/Secondary (0-	Ť	e completed) College (1	-4or 5+)	(Give	kind of v DO NOT	vork done d use retired)	uring most	t of workii	ng				,	
21	filed wit Hygiene other tha	Son			2		Carr	ente	r				C	onstru	cti	on	
<u>n</u>	tal Hy	Be	17. Father's Name (First, Mid									(First, Middl		n Sumame)			
Zla	2 should be and Mental Is marked ( aumatic ev	ဥ	John Lee Sta									ae Reni					
Maryland	iges 1 and 2 should be filed within 72 hours after deeth with the Manjan nt of Health and Mental Hygiene. If item 27 is marked other than "natural", or iteme 23a or 28a-f show or other traumatic event, the Madigal Examinar must be notified at		19a. Informant's Name/Relat	. , , ,				e Serve				I Route Numi					
dî.	1 and Health em 27 other tr		Gloria A. Sta	Ley -	Wife	20b.	Place of Dispo	osition (A	ame of			- Bunke		ocation - Ci			
Baltimore,	permit. Pages 1 Depertment of H Important: If ite eny injury or ot		x Burial 2 ☐ Cremat	on 3 🗆 F	Removal from	State	cemetery, cre				2/2	100					
Ħ	nit. P entme ortan injur		21. Signature of Funeral/Sen			Bro	ownsvi]		IGTS. and Addres					ownsvi		*	
ä	Depe Impo		Profit	8	2/200	M	970				Lac	kles-S pers l	-				me
			23a. Part1. Enter the disease shock, or heart failure.	, or compl	ications that co	aused the dea	th. Do not en	ter the m	ode of dying	, such as	cardiac o	r respiratory	arrest,	<del>y , w v</del>	2.74	Approxima Interval Be	
1	Physician		Immediate Cause (Final disease or condition		_	rracra	loid	Hen	norrl	2000						Onset and	
ed .	/Medical		resulting in death)		Due to (	or as a conse	quence of):	, , ,		.000					<u> </u>	J 10 C.	2.63
	Examiner	_	Sequentially list conditions,		o												
•	Ped isi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	~	Due to (	or as a conse	quante of):										
	and ai-tran	хап	that initiated events resulting in death) Last	1	Due to (	or as a conse	quence of):						_		-		
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.89	tificate ng phy es the	edic			,												
Вох	n cer andir use	2	IF FEMALE: 23b. Was decedent pregnant	2	3c. If yes, out	come of pregnirth 2 ☐ Fet		Tectonio	pregnancy					23d. Date of	f delive	гу	
	death	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No			ant at time of		Other (						Month		Day	Year
P.O.	d by the	Phy	9 Unknown										-				
	w requires that the de been signed by the should be detached	Completed by Physician/Med	Part II. Other significant con		ntributing to de	eath but not re	sulting in the u	inderlying	cause give	n in Part I.			tobacco Yes 2	use contribu	te to th		death? Túnknown
Ö	requ	etec	Hypertens	(01)													
Division of Vital Records,	e la has	ig E							_			24a. Wa auto	s an opsy iomed?	24b. We prio dea	r to con	psy findings	available cause of
ā		ပိ	25. Was case referred to me	tings	-							1 Yes	28 N	0 1	Yes	2 No	
⋽		To Be	examiner?  1 Yes 2 No	-	lospital:	npatient 2	] ER/Outpatier	nt 3[]	Othe	-		<i>(Check only</i> ne 5 ☐ Res		e ClOthas	(5	.1	
ō	g Phys er this eral di		27. Manner of Death		28a. Date o		28b. Time o		28c. Injury	at		28d. Describe			Specify	7	
Ö	Attending r death. ector: After by the fune	atio	1 ANatural 5 ☐ Pe 2 ☐ Accident inv	nding estigation	[NOTA:	n, Day reary	Injury	М	Work 1 ☐ Y	es 2 🗆 N	No						
<u>₹</u>	of or Attending Pieter death.  Director: After to in by the funera	Certification:		uld not be ermined	28e. Place buildir	of Injury - At h	nome, farm, st	reet, fact	ory, office		2	28f. Location City or To	(Street a	nd Number	or Rura	I Route Nur	mber,
	ospitel o hours ef unsrei Di ly filled ir																
	Hospitel	edical	29a Certifier (Check only one) Cert	lying Phy cal Exami	ner: On the ba	isis of examin	owladge dest ation and/or in	h secure vestigati	d at the time on, in my op	e data and inion, deat	d place, a th occurre	and due to the ed at the time	date an	d place, and	of 16 et due to	the cause(	(s)
	To the Hospitel or Atten within 24 hours efter deat To the Funstel Director: completely filled in by the	Med	29b. Signature and title of ce		and manr	ier Stated.											
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	UX,		30. Name and address of per	son who co		e of death (Ite	m 23a) (Tvoe	Print)					_/	- / -			
	. 1		Brian T	Tull.			, ( )   0	10	NG	CEPN	257	303 Treet	BA	Himus	Ry. 1	りつ	2/20/
	Sta		31. Date filed (Month, Day, Y	0 1 21	32. 8	gistrar's Sign	ature	for A	F .								
	Registi	ar	FED	O T Y	200	4355	25 /4	THE STATE OF									

		,	1 - For State	State of M	larylar			nt of H		and M	_	1	006	Π	1,228	
			Registrar  1. Decedent's Name (First, Middle, La	est)		Cel	unca	le UI L	Jeani		2. Date of De	Reg. No.	000	3. 1	Time of Death	_
П	Physici			_eroy	W	/hite					Month -	O Day	2000 C	1	3:35AM	
	/Medic Examin		4a. Facility Name (If not institution, gire				4b. City	, Town, or	Location o	f Death	- 0	4c. (	County of Dea	-	, = -, 1	_
			11819 McMullen I	Highway			Cu	mberl	and				egany			
	Funeral Director		215-20-5553	ISM OFF	ge (In yrs. <b>76</b>	last birthday) Yrs.	II Und	er 1 Year Days	If Under : Hours	Min.	8. Date of Bir Month, Pa Aug 1	th, 192	9. Bi	thplace (	State or Foreign	
	and		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. In	side City Limits	_
	Maryl f ehc	ō	MD Allega	ny		Cumb	erla	nd						1)	X)Yes 2□No	
	r 28a	Director	10e. Street and Number				10f. Z	ip Code				10g. Citiz	en of What C	ountry?		-
	th wit		11819 McMullen I	Highway				2	21502	-			USA			
	r dee	Funerai	11. Marital Status	12. Was Decedent Armed Forces	?	i.S. 13.	Vas Dec f Yes, sp	edent of Hi	spanic Orig	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	)- 1	4. Race - Am Black, Wh		dian,	_
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 √ Yes 2 ☐ II Yes, Give Year or Dates:	INANI		1 🗆 Yes	\/	Specify:				Specify: Wh			
9	within 72 hours after deeth with the Maryland ene. Then "naturel" or Iteme 23e or 28e-f ehow he Medical Examinar must be notified at	edt	15. Decedent's E			16a. Dece							d of Business			_
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D L	lould be filled v Mental Flygie barked other t	Be	17. Father's Name (First, Middle, Las	)							e (First, Middle, Bennett			c		
Z	Men Men Marke Marke	ပ္	Clyde White							,		,				_
, Maryland 21215-0036	and 2 sh alth and 127 le m er treum		19a. Informant's Name/Relationship Lois Peck		panio	n 118	19 M	cMull	en Hv	vy.	Cumb Cumi	er, City or berlar	nd N	21p Code 1D 2	1502	
Baltimore,	cemetery, crematory or other place)										2/8/2006		ation - City o	r Town, S	MD	
Baltii	permit. P Departm Importer any njur		21. Signature of Funeral Service Lice		111	. 22					me, PA		NID 045	00		
	_		23a. Parti. Enter the disease, or con shock or heart lailure. List only	plications that cause	ed the deat	th. Do not ent					: Cumbe		MD 215	Appr	oximate	-
	Physician		Immediate Cause (Final								FALL		N	Onse	val Between et and Death	
	Physician /Medical		disease or condition resulting in death)	a. Due to (or as			0 -	77KD	INC	17	7722	-// /		9	1110.	
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7	₽ ≅	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as			4 4 4	114						1	wa (	
	ecute and trens	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as	A BET		461	411	4)					10	yrs	_
8760,	icate be executed physicien and s the burial-trensit	a E		Due to (or as	s a consec	quence or):										
687	icate phys s the	edicai		_ d								Y.		<del></del>		-
Box (	eath certific ettending p for use as	N/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	e of pregna							2:	3d. Date of de	elivery		
ă.	The law requires that the death certific ste hes been signed by the ettending p page 2 should be deteched for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	1☐Live birth 4☐Pregnant a			]Ectopic ] Other (	pregnancy specify)			1.1		Month	Day	Year	
Ö	that the de led by the e deteched i	hys	9 Unknown	9□ Unknown							-	_				
'n	w requires that been signed I should be det	۵	Part II. Dther significant conditions	contributing to death	but not res	sulting in the u	nderlying	cause give	en in Part I.			/	e contribute			
ord	een s	Completed	108/12100	125							1,000	Yes 2L			4 □Unknown	
ec	e law	nple									24a. Was		24b. Were a	utopsy li completi	ndings available on of cause of	
<u>a</u>	n: Th		RELEASED								1 ☐ Yes	2 No	death? 1 ☐ Ye	s 2 🗆 l	No	
₹	Physicien: rthis certifice ral director, p	Be c	25. Was case referred to medical examiner?  Yes 2 No	Hospital:		3500		Othe	·-		Check only					-
ŏ	Phy or this oral d	: To	27. Manner of Death	1 ☐ Inpat 28a. Date of Inj	ury	ER/Outpatier 28b. Time o		28c. Injury Work	4 🗀 140	rsing Ho	28d. Describe		Other (Sp	өсіту)		
<u>o</u>	nding ath. r: Afte e fun	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, D	ay Year)	Injury	М		<br Yes 2 □	No						
Division of Vital Records, P.O.	l or Atten efter deal Director: I in by the	Certification:	3 ☐ Suicide 6 ☐ Could not determined	286. Place of If	njury - At h atc. (Speci	ome, farm, sti	eet, facto	ery, office			28l Location ( City or To		Number or F	Rural Rou	te Number,	_
	To the Hospital or Attending Physicien: The law within 24 hours eller death.  To the Funerel Director: Affer this certificate has completely filled in by the funeral director, page 2	Medical Co	(Check only 2 Medical Exa	hysician: To the bes miner: On the basis	of examina	owledge, deat ation and/or in	h occurre vestigatio	d at the tim	ie, date an pinion, dea	d place, th occurr	and due to the	cause(s) a	and manner a	is stated.	ause(s)	_
	thin 2 the the	Med	29b. Signature and title of certifier	and manner s	tated.		2	9c. License	number			29d Date	signed (Mor	ith Day	Year)	_
)	E 3 E 8			1/2-MO						2			106/	-		
7	L		30. Name and address of person who		death (Ite	m 23a) (Tyne	Print)	D3								_
	8		EUGENE NAL	LIN MD	909	BSE	0~	DAIN	EC	44	3 cm Lan	DM	0 21	502		
35	Sta Registi		31. Date filed (Month, Day, Year)  FFR 1 4	100	trar's Sign	ature	and the	9								

Weaver Zelma.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

, ~	•	1 - For State Registrar	State of Maryland /	Department of He Certificate of D		lygiene 005	04229
		Decedent's Name (First, Middle,	Last)		2. Date of Month		3. Time of Death
Physicia /Medica		Zelma G.	Weaver		Feb	ruary 60 200	6 40 YAM
Examine	er	4a. Facility Name (If not institution,	1 1 1 1 1	4b. City, Town, or L	ocation of Death	4c. County of Dea	ath.
5			ELOY NWSING HO 6. Sex 7. Age (In yrs last b.	inthday) If Under 1 Year	If Under 24 Hrs. 8. Date of	Birth 9. Bi	rthplace (State or Foreign
Funeral Director		299-14-5684	1□M 21XF 85	Yrs. Months Days	Hours Min. (Month,		Ohio
2		Usual Residence of Decedent  10a. State 10b. County	10c City Tox	wn or Location			10d. Inside City Limits
Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ò		Washington	Boonsboro			1 ☐ Yes 2 🛣 No
r 28a	Director	10e. Street and Number		10f. Zip Code		10g. Citizen of What C	country?
23a o	ai D	8507 Mapleville	e Rd.		21713		U.S.A
er m	Funerai	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of His If Yes, specify Cuban	panic Origin? (Specify Yes or , Mexican, Puerto Rican, etc.)	No- 14. Race - Am Black, Wh	
l o	by Fi	1 Never Married 2 Marrie 3 ☑ Widowed 4 Divorced	od 1 ∏Yes 2 📉 No If Yes, Give Year or Dates:	1 ☐ Yes 2 🌠 No	Specify:	Specify:	White
atura cal E	ted	15. Decedent's	s Education 16a	a. Decedent's Usual Occupat	ion	16b. Kind of Business	s/Industry
Med	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	(Give kind of work done du life. DO NOT use retired)			
at a		17. Father's Name (First, Middle, L.	5	Libraria	n 18. Mother's Name (First, Midd		brary
to per	o Be	Jonas G. G				rude Hittle	
Tati	은	19a. Informant's Name/Relationshi		b. Mailing Address (Street ar	nd Number or Rural Route Nur	nber, City or Town, State:	Zip Code)
er trau		Scott Weaver (Sc	on) 1:	339 Perry Pla	ce N.W. Washir	gton, D.C. 2	00140
r oth		20a. Method of Disposition 1 □ Burial 2 🖒 Cremation	2 Demoval from State   cemete	of Disposition (Name of ery, crematory or other place,		20c. Location - City o	
tant:		*4 □ Donation 5 □ Other (Spe	ecify) SMITH	sburg Cremato —	ry 2006	Smithsbu	rg,Md.
any in		21. Signature of Funeral Service Li	icensee MO1414	22. Name and Address	of Facility		_
					Punoral Here	.2525 Bradbu	
	_	23a. Part1. Enter the disease, or o	complications that caused the death. Do	J.L. Davis	Funeral Home	mithsburg,M	d. 21783 Approximate
ician		shock, or heart failure. List o Immediate Cause (Final	complications that caused the death. Do	J.I. Davis	Funeral Home	mithsburg,M	a. 21783
dical		shock, or heart failure. List o	complications that caused the death. Do	J.I. Davis not enter the mode of dying,	Funeral Home	mithsburg,M	d. 21783 Approximate Interval Between
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Registrar

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Khalid Wascen
31. Date filed (Month, Day, Year)
FEB 1 4 2006

DHMH 17 Rev 1/2001

M.D. 1126 Opal Court Hagerstown MD. 21740

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 2006 January 30,\_ Helen Jewel Wade /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 02/27/1928 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Virginia **Funeral** 1□M 2≯F Yrs. Director 225-32-3072 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "natural", or items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 No Director MD Harford Aberdeen 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? U.S.A. 21001 6 East Inca Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mildred Pearl Pipkin Oliver Orr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 s Department of Health ar Important: if item 27 ie any injury or other trau 3205 Spotted Horse Dr., Killeen, TX 76542 Linda Nelson (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Harford Mem. Gardens 02/04/06 Aberdeen, Maryland Signature of Funeral Service Licenses Tarring-Cargo Funeral Home, P.A. 333 South Parke St., Aberdeen, MD 21001 29a- Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner signed by the attending physicien and the deteched for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 10m 24b. Were autopsy findings available
that to completion of cause of death?
1 Yes 2 No 24a. Was an hes autopsy performed? Yes 2 4 No 1 ☐ Yes Division of Vital 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 LNO 1 Do tient 2 ER/Outpatient 3 DOA Medicai Certification; To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 Natural 5 Pending investigation death. 1 Tes 2 No 2 Accident Director: 6 Could not be determined 3 Suicide To the Hospital or Att within 24 hours after de To the Funeral Directo completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State FEB 1 4 2006 Registrar Marie

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Matthew Casev Watson 28, January 2006 11:15 PM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 12441 Uncle Charlie's Spur Dunkirk Calvert 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1**⊠**M 2□F 219-13-7280 18 Director Yrs. 22, 1987 Wash. D.C. Usual Residence of Decedent with the Maryjand 10a State 10b. County 10c. City, Town or Location "natural, or itams 23a or 28a-f ahow edical Ezandrar must be notilled at 10d. Inside City Limits Director 1 ☐ Yes 2X No Anne Arundel Rose Haven 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7012 Dover Avenue 20714 Pages 1 and 2 should be filed within 72 hours after death vent of the alth and Mental Hygiene.

MRI: If Item 27 is marked other than "natural", or Itams 23 marked other than "natural", or Itams 23 may or other traumatic avent, "In Medical Expiris me much USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Student Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Robert Adair Watson Bonita Jean Holson ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert A. Watson (father) 7012 Dover Avenue Rose Haven, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. Lee Crematory 4 Donation 5 Other (Specify) Feb 1, 2006 Clinton, MD 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, PA Gary J. Goff 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory to Due to (or as a consequence of): **Physician** disease or condition resulting in death) tailure Days /Medical Examiner Osteosarcon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ should I 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an certificate has t irector, page 2 s autopsy performed? 2 No 1 Yes or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 🗌 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death
Natural
2 ☐ Accident 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending investigation death. 1 ☐ Yes 2 ☐ No s after death filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Dey, Year) 30 MD 33638 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Shana a colos III Michigan Ave NW Washington DC 32. Registras Signature 31. Date filed (Month, Day, Year) State Beauce 2006 Registrar

			1 - For State Registrar AMEND#12, perFH	State of Mary ,1/31/06,DPS,M			t of H	ealth and	-		'HHA	04232
175	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last)     William Works     4a. Facility Name (If not institution, give s	treet and number)		4h Ciby 1	Tour or	Location of De		ary	27, 2006	
	Exami	ier	Montgomery Genera				ney	Location of De	ratin		4c. County of Deat  Montgome	
e de la constant de l	Funeral Director		5. Social Security Number 6. Sex		yrs. last birthday) Yrs.	If Under Months	1 Year Days	Il Under 24 H Hours M		Birth Day, Yea	9. Birt Co	hplace (State or Foreign untry) ansas
	show	ក	10a. State 10b. County	100	. City, Town or Lo							10d. Inside City Limits
	h the h	Director	VA Fairfax  10e. Street and Number		Alexand	10f. Zip	Code			10g. (	Citizen of What Co	1 X Yes 2 □ No
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2-0036	72 hours after death with the Maryland naturel', or iteme 23a or 28a-f show disal Examinar must be rodified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	2. Was Decedent Ever Armed Forces? 1 ØYes 2 No If Yes, Give Year or Dates: Unk		Was Decede II Yes, speci 1 ☐ Yes 2		spanic Origin? n, Mexican, Pu Specify:	(Specify Yes or erto Rican, etc.	No-	14. Race - Ame Black, White Specify: B1	e, etc.
0-612	within 72 hours ne. than "naturei", n Medical Exa	Completed	15. Decedent's Educ (Specify only highest grade	ation	16a. Dece (Give life.		k done d e retired)	tion uring most of v	vorking		Kind of Business/	·
7	filed v Hygie other t		12 17. Father's Name (First, Middle, Last)		Pos	tal Cl		18. Mother's N	lame (First, Mic		.S. Post	Office
ylan	Mental Mental Brked c	To Be	Jason S. Works						Lou Ham		on Sumame)	
Mar	permit. Pages 1 and 2 should b Department of Health and Ments Important: If Item 27 is marked eny injury or other traumatic e		19a. Informant's Name/Relationship (Type Bobby Works (	brother)							or Town, State, Z	
e e	ss t an of Heal item 2 r other		2va. Method of Disposition	20	b. Place of Dispo cemetery, crei				Silver		ing, MD Location - City or	20906 Town, State
Daillimor	tment tant: H		1 X Nurial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	l l	incoln	Memori	ial	2/		Su	itland, M	Maryland
Da	permit. Departn imports eny inju		21. Signature of Funeral Service License	Clybry	- 22 - 7	2. Name and	Address	ol Facility M	cGuire	Fune	ral Servi	ice
	Physician /Medical		23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)		death. Do not ent	er the mode	of dying	, such as card	ac or respirator	y arrest,	ington, [	Approximate Interval Between Onset and Death
,00700	ate be executed by sician and the buriat-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a con	sequence of):	CTIVE	Pu	LMON	any 1	) IS BA	956	
.C. DOY	The law requires that the death certific. Ite has been signed by the attending pl page 2 should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	Ectopic pre Other (spe					23d. Date of deli- Month	very Day Year
ords, r	w requires that been signed t should be det	by	Part II. Other significant conditions cont	ributing to death but not	resulting in the u	nderlying ca	use givei	n in Part I.		id tobacco		the cause of death?
אסטר ומ	as a	Completed							24a. W ai pe 1  Ye	utopsy erformed?	prior to c	topsy lindings available ompletion of cause of
21 >	s certif	o Be	25. Was case referred to medical examinar?  1 Des 2 No	spital:	2 ☐ ER/Outpatier		Othor		eath Check on			
5	ding Phys n. After this funeral di	$\vdash$	27. Manner of Death	28a. Date of Injury (Month, Day Yea			c. Injury Work	4   Nursing	T		6 ☐Other (Specury occurred	ify)
	or Attendi after death. Director: A in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, str	М	1 🗆 Y	es 2□No	28f. Locatio City or	n (Street a Town, Sta	and Number or Rui te)	ral Route Number,
-	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier 1 Certifying Physi (Check only one) 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death	occurred a vestigation, i	t the time in my opi	e, date and pla nion, death oc	ce, and due to t	he cause( ne, date a	s) and manner as nd place, and due	stated. to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	no N	20		License			29d. D	ate signed (Month	, Day, Year)
			30. Name and address of person who con	7/1/	//	D	00	3041	4	JAR	MARY 2	7, 2006
	10		JOHN HERRING	mpleed cause of death (	101 RI	NCK F	2411	p Do	DIN	EV	MARULA	ano
	Sta Registr		31. Date liled (Month, Day, Year)	32. Figistrar's Si	gnature	oute		12.0	1	1	110000 700	7, 2006 AND

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			1 - For Stete Registrar	State of I	Marylan		artment of F		and Mental H	/giene	nna	04233
	Physici /Medio		- I ICI CI ICI	llian		Winok			2. Date of D Month Janua	cy 26	, 2006	8:40A. M
	Examir	ner	4a. Facility Name (If not institution, Brighton Garder  5. Social Security Number	s@Friends			4b. City, Town, o Chevy (			M	County of Delontgom	ery
	Funeral Director		413-03-8013 Usual Residence of Decedent	1□M 2XF		91 Yrs.	Months Days	Hours	24 Hrs. 8. Date of B Min. (Month, D Sept. 2	2,191	4 Te	irthplace (State or Foreign Country) NNESSEE
	e Marylar 8a-f show	ctor	Maryland Montgo	mery		y, Town or Lo Chevy						10d. Inside City Limits 1X Yes 2 □ No
	ath with the 23a or 2	Funeral Director	5555 Friendship				10f. Zip Code 2081			Uni	ted Sta	ates
2-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show may joury or other traumatic event, if a Medice. Exacult were rest by credition and once.	by	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decede Armed Force 1 Tes 2 If Yes, Give Year or Date	s? ⊒ <b>X</b> lo		Was Decedent of H fYes, specify Cuba 1 ☐ Yes 2 ☐️️XNo	lispanic Origan, Mexican Specify:	gin? (Specify Yes or N , Puerto Rican, etc.)	0-	14. Race - An Black, Wh Specify:	nerican Indian, hite, etc. White
21215-0	d within 72 h giene. er than "natu i II e Medice.	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12) 12	Education grade completed) College (1-4d	or 5+) 1-4	(Give life.	dent's Usual Occup kind of work done DO NOT use retired istrative	during most 1)		Sour	nd of Busines nd and ustry	s/Industry Entertainmen
Maryland	uld be file Mental Hygurked othe	To Be C	17. Father's Name (First, Middle, La Soley	,	sephs			18. Mothe Gussi	r's Name (First, Middl .e	e, Maiden	Sumame) Turne	r
	l and 2 sho Health and h om 27 Is ma		19a. Informant's Name/Relationship Henry S. Winokur		20h D	6613	Elgin Lar	ne, W.	Bethesda,	Mary!	land 20	081 <b>7-</b> 5443
Baltimore,	thent of Hant: If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Spe	cify)		ean Me		ardens	Date 1/30/2006	Olne	ey,Mar	
Ba	Depar Impor any ir		21. Signature of Funeral Service Li	Sogwood	e P	2 2 4	Name and Address Onald V. 400 Powde	Borgv Borgv r Mil	vardt Funer 11 Road Bel	al H	ome, P. 11e, M	A aryland20705
Ä	Pnysician /Medical		shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	nly one cause on each Aspira	n line.	Pneumo		<b>3</b> ,				Approximate Interval Between Onset and Death 2weeks
	Examiner	er	Sequentially list conditions, if any, leading to immediate Curse Disease or injury	Dement								5years
8760,	cate be executed physician and the burial-transit	edicai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or d.	as a consequ	uence of):						
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 ☐ Fetal tat time of de	death 3	Ectopic pregnancy Other (specify)			2	23d. Date of d Month	elivery Day Year
rds, P.	quires that an signed b uld be deta		Part II. Other significant condition Insulin Dependen			ulting in the u	nderlying cause give	en in Part I.		tobacco u Yes 2[		to the cause of death? Probably 4XDUnknown
al Records,	sician: The law requir s certificate has been si lirector, page 2 should	Completed by							24a. Wa auto peri 1 \subseteq Yes		24b. Were a prior to death?	autopsy findings available completion of cause of
on of Vital	ding Phy n. After this funeral d	ıtion: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investiga	28a. Date of li (Month,	atient 2     njury Day Year)	ER/Outpatier 28b. Time of Injury	28c. Injun Worl	er: 4 □ Nu	28d. Describe	idence 6		smisted Livin
Division	al or Attendi s after death. Il Director: A od in by the fu	Certification:	3 Suicide 6 Could no determin	ad 286. Place of	Injury - At ho etc. (Specify	me, farm, str	eet, factory, office			(Street and own, State)		Ru <i>ral Rout</i> e Number,
	To the Hospital or A within 24 hours after To the Funeral Directorpletely filled in by	Medical (	(Check only ) Medical Ex	Physician: To the be teminer: On the basis and manner	or examinar	wledge, deatl ion and/or in	vestigation, in my o	pinion, deat	d place, and due to the h occurred at the time	, date and	place, and du	ue to the cause(s)
•	Mith To 1	W	29b. Signature and title of socifier	) mo			29c. Licenso	e number				oth, Day, Year) 5, 2006
0	20		30. Name and address of person will David E. Rogers	, M.D.	death (Item	23a) (Type, ISCONS			:00 Chevy C	hase	, Mary	Land 20815
	Sta Registr		31. Date filed (Month Pay Year) 3 1	2006 32. Bgi	strar's Signal	ture di	raide					

		•		rtment of Health and Menta ificate of Death	Hygiene Reg. No. 006 04234
	Physici		1. Decedent's Name (First, Middle, Last)	Mor	of Death 3. Time of Death 11 Pay Year 9.45 PM
	/Medio		4a, Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death CARROLL
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 100 Yrs.	If Under Year If Under 24 Hrs. 8. Date Months Days Hours Min. Apr	9. Birthplace (State or Foreign Courting)
	ס		Usual Residence of Decedent         10a. State         10b. County         10c. City, Town or Loc.	ation	10d. Inside City Limits
	a-f sho	ctor	MD Carroll	Sykesville	1 ☐ Yes 2 No
	h with the 23a or 28 st be no	Funeral Director	10e. Street and Number 710 Obrecht Road	10f. Zip Code 21784	10g. Citizen of What Country? USA
36	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "natural", or items 23a or 28a-f show or other traumatic avent, the Machael Examiner must be notified at or other traumatic avent, the Machael Examiner must be notified at	by Funer	1 Never Married 2 Married 1 ☐ Yes 3 No	as Decedent of Hispanic Origin? (Specify Ye Yes, specify Cuban, Mexican, Puerto Rican, e Yes 2 No Specify:	s or No- etc.)  14. Race - American Indian, Black, White, etc.  Specify: White
215-0036	within 72 hou ene. than natura	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ent's Usual Occupation ind of work done during most of working O NOT use retired)	16b. Kind of Business/Industry
d 21	12 should be filed within in and Mental Hygiene. 7 is marked other than "Iraumatic avent, It's Max		17. Father's Name (First, Middle, Last)	Teacher  18. Mother's Name (First,	Education  Middle, Maiden Sumame)
Maryland	Mental Mental arkad c	To Be	Charles S. Hayden		arrison Spencer
Mar	od 2 sho lith and 27 Is m			Address (Street and Number or Rural Route X 423 St. Michael	
altimore,	Pages 1 and 2 nent of Health int: If itam 27 l		20a. Method of Disposition 20b. Place of Dis	of atory or other place)  Lty Cremation 2/16	20c. Location - City or Town, State  5/06 Sykesville, MD
Balti	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee  HA  Start  Star	Name and Address of Facility AIGHT FUNRAL HOME	& CHAPEL (Box 195) 34 (410)-795-1400
Н			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	r the mode of dying, such as cardiac or respin	ratory arrest, Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a	10.el	4 days
ŧ.	Examiner	_	Sequentially list conditions,  b. Due to cras a consequence of		
X	tuted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.		
8760,	ate be executed hysician and the burial-transit	dical Exa	resulting in death) Last  Due to (or as a consequence of):  d.		
9	leath certifica attending ph	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
P.O. Box	tt the death or by the atten tached for us	Physician/Me	23b. Was decedent pregnant 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)	Month Day Year
	uires that signed b	b	Part II. Other significant conditions contributing to death but not resulting in the un	iderlying cause given in Part I. 23	3e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
Secol	e law requ has been ge 2 shoulk	Completed			a. Was an autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?
talF	an: The trificate hator, page	e)	25. Was case referred to medical	1 [ 26. Place of Death (Chec	□ Yes 2□No 1□Yes 2□No ck only one)
) \	hysician: his certific al director,	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatien		☐ Residence 6 ☐ Other (Specify)
ono	ding P th. After t funera	tlon:	27. Manner of Death  Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  Injury	28c. Injury at Work?  M 1 Yes 2 No	escribe how injury occurred
Division of Vital Records,	or Atten after dear Diractor	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office 28f. Lo	cation (Street and Number or Rural Route Number, ty or Town, State)
_	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as it	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death one)  Certifying Physician: To the basis of examination and/or invane and manner stated.	n occurred at the time, date and place, and du vestigation, in my opinion, death occurred at the	e to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
	To the To the Comp	Me	29b. Signature and title of certifier	29c. License number D34849	29d. Date signed (Month, Day, Year) February 15, 2006
	30		30. Name and address of person who completed cause of death (Item 23a) (Type.	Print) Road Elde	February 15, 2006 ersburg MD 21784
	St Regis	ate trar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	de	
			FER TO COMO TO THE PART OF THE		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Regist Amend Item #12,18819b Per FH 5853 16348 965 94th 2. Date of Death 3. Time of Death Day Year **Physician** 10:02PM FEBRUARY ONG-13 2006 /Medical Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Memoria DITO th mol 7. Age (Inlyrs. last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 ☐ M 2 😿 F Yrs. Director Marylani Usual Residence of Decedent filed within 72 hours after deeth with the Maryland Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "naturel", or Iteme 23a or 28a-f ehow vent, the Mudical Examinar must be notified at 1 ZYes 2 □ No Director 10e. Street and Number 10g. Citizen of Whal Country? 10f. Zip Code USA 1212 Ulyue Funeral Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 XXYes 2 Specify: Cuban þ ac 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT) se retired. 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry onalny (0-12) College (1-4or 5+)  $\infty$ Father's Name (First, Middle, Last) Be Mother's Name (First, Middle 1 and 2 should be Health and Mental is marked voe. Print) 19a\_letormant's Name/Relationship ( 19b. Mailin Auress (Street and Number at Papago nt of Health a :: If Item 27 is or other tree Method of Disposition

Weburial 2 Cremation Pages 1 3 Removal from State Department important: If any injury o 4 ☐ Donation 5 ☐ Other (Specify) permit 21. Signature of Funeral Service Licensee Approximate Interval Betw Onset 23a. Part1. Enter the disease, or complications that caused the death. Do not ent-shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) nset and Death Physician Brainstem Strok week /Medical Due to (or as a consequence of): Examiner Hunertensin MURLITS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien end for use as the burial-transit Hears abeles Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 | Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 3 Probably 4 Wunknown 1 ☐ Yes 2 ☐ No Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed/ 2 000 1 Yes 2 No 1 TYes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☐ No 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending death. 1 Yes 2 No within 24 hours efter death To the Funeral Director: A completely filled in by the t 2 Accident investigation М 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death accurred at the time, date and place, and due to the cause(s) and marrier as stated Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY, 13, 2006 AT 2438946 ,MI 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ABBULNOUR

31. Date filed (Month, Day, Year)

MA

32. Registrar's Signature

and the

DHMH 17 Rev 1/2001

UNION MEMORIAL HOSPITAL, MD

		For State	State of Maryland / D	Department of Certificate			2006	04236
		Registrar  1. Decedent's Name (First, Middle, L.		20,111,0010		2. Date of Death		3. Time of Death
Physici			toniak				9, 2006	6:10 p <sup>N</sup>
/Medio Examir		4a. Facility Name (If not institution, gi		4b. City, To	wn, or Location of Death		4c. County of Death	
Exami		Stella Maris Ho	ospice	Time	onium		Baltimor	e
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last birt	thday) If Under 1		8. Date of Birth (Month, Day, Ye		place (State or Foreig
Director		102-20-2102	<sup>1□M 2</sup> X <sup>F</sup> 72	Yrs.	Days Hours Will.	Jan. 24,	1934 Pen	nsylvania
pu *		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
anyle •ho	2	· ·						1 Yes 2 No
the N	Director	Maryland Baltimo	ore Towso	10f. Zip Ci	ada	100	Citizen of What Cou	X
s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Heelih and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f ehow other traumatic event, the Madical Examiner mast be inclified at	Ö		s Drive		1286	109.	USA	muy?
na 23	Completed by Funeral	11. Marital Status	12. Was Decedent Ever in U.S.			pecify Yes or No-	14. Race - Amer	ican Indian
riter	핕	1 Never Married 2 Married	Armed Forces?		nt of Hispanic Origin? (Sp Cuban, Mexican, Puerto	Rican, etc.)	Black, White	
urs a	by	3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐	No Specify:		Specify: Wh	ite
72 ho	ted	15. Decedent's E (Specify only highest g	ducation 16a.	Decedent's Usual (	Occupation done during most of wor.	16b	. Kind of Business/l	ndustry
within ene. than "	pie	Elementary/Secondary (0-12)		life. DO NOT use	retired)	nig .		
filed with Hygiene. other ther	Con		College (1-4or 5+) +3	Register	ed Nurse		Nursin	g
d oth	Be	17. Father's Name (First, Middle, Las				ne (First, Middle, Maid		
d Mental	2	Elmer Ma	ındler		Althea	a Gibs	on	
and and is mu		19a. Informant's Name/Relationship		100 30 10-1	Street and Number or Ru	ral Route Number, Cit	ty or Town, State, Z	ip Code)
and eelth m 27		Mr. Joseph Antoni		L5 Far Hil		Towson, <u>Ma</u> i		
permit. Pages 1 and 2 Department of Heelth a Important: if item 27 ti any injury or othar tra ance.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3	l comotor	Disposition (Name ry, crematory or other	of er place)	Date 20c	. Location - City or T	own, State
ment ment ment ment		4 ☐Donation 5 ☐ Other (Spec	Holy 1	rinity Or	rth.Cem. 2/1	L3/06 E	lkridge, 1	Maryland
Departiment important in portant		21. Signature of Funeral Service Lice	n See ( )	The second second	Address of Facility		1050 You	
å. Q ⊆ <b>ä</b> ä			nplications that caused the death. Do n		vson Funeral		t.Towson,	4d.21204
Physician /Medical /Sician and portial-transit	Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of Due to (or as a consequence	of):				
cate be e chysician the buria	cai		d					
requires that the death certificate be executed een signed by the attending physician and nould be detached for use es the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic preg 5 □ Other (spec			23d. Date of deli- Month	very Day Year
that t	モ	Part II. Other significant conditions	contributing to death but not resulting in	the underlying caus	se given in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
sign d be	d by			, ,	•	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 🛣 Unknow
w require been si	ete							
The lav	Completed					24a. Was an autopsy performed	prior to c death?	topsy findings availab completion of cause of 2 \square No
Physician: this certific ral director,	Be	25. Was case referred to medical examiner?			7	th (Check only one)		
hysic his ca	유	1 ☐ Yes 2 📉 No	Hospital: 1 Inpatient 2 ER/Ou			ome 5 Residence	6 KiOther (Spec	try) HOSPICE
ath. rr: After t	ation;	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigate	(Month, Day Year) II	Time of njury M	l Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	njury occurred	
To the Hospital or Attending Physician: The law within 24 hours effer death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2.	Medical Certification;	3 Suicide 6 Could not 4 Homicide determine	28e. Place of Injury - At home, fa building, etc. (Specify)	rm, street, factory, o	office	28f. Location (Street City or Town, St		ral Route Number,
• Hospital or 124 hours effe • Funeral Dir letely filled in	dicai	29a. Certifier 1 Certifying F (Check only one) 2 Medical Exa	hysician: To the best of my knowledge iminer: On the basis of examination an and manner stated.	dor investigation, in	the time, date and place my opinion, death occu	, and due to the cause rred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	ž	29b. Signature and title of sertifier			cense number	29d.	Date signed (Month	Dey, Year)
To th withir To th comp					143725		11.11	,
To th within To th		12		1 -	13/2	1	2/10/0	6
To th within		30. Name and address of person who	o completed cause of death (Item 23a)		125		2/10/0	6
To the comp		30. Name and address of person who		(Type, Print)		MD 21093	2/10/0	6

DHMH 17 Rev 1/2001

FEBRUARY 9, 2006 6:10 p.m.

JOAN ANTONIAK

		1 - State Registrar	State of Maryland		irtment of tificate of			iene 006	04237
Physic	ian	1. Decedent's Name (First, Middle, Last)	T. a. a. w.		Alexan	der	2. Date of Death Month Februar		3. Time of Death 7:27PM M
/Medi Exami	cal	Betty  4a. Facility Name (If not institution, give st  Southern Maryla				or Location of Death	100144	4c. County of Dea Prince G	ith
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs. last	t birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth Month, Day Jan .	9. Bi 7, 1934 V1	rthplace (State or Foreign ountry) rginia
the Maryland 288-f ehow	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Charles  10e. Street and Number	10c. City, 1		wAldorf		10	0g. Citizen of What C	10d. Inside City Limits 1 ☐ Yes 2 ☐ No ountry?
ithin 72 hours after death with the Maryland ite. "natural", or Iteme 23a or 28a-f ehow Medical Everilland items in Medical Everyland in the Indianal Control in Medical Everyland in the Indianal Control in the Indiana Control Indiana Control Indiana Control Indiana Control Indiana Cont	eted by Funeral D	2005 St. Thomas D  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Educt (Specify only highest grade)	2. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No II Yes, Give Year or Dates:	13. \	f Yes, specify Cu	upation	pecify Yes or No- prican, etc.)	14. Race - Am Black, Wh	encan Indian, ite, etc. ite
and years 2 12.12.2 should be filed within 72 and Mental Hygiene. Is marked other then "nat aumatic event, the Medical	Be Completed	Elementary/Secondary (0-12) 2 t h 17. Father's Name (First, Middle, Last)	College (1-4or 5+)	life. l Clerk	DO NOT use retii	18. Mother's Nam	e (First, Middle, M	WalMart Maiden Sumame) e Johnson	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If item 27 is marked other then "natural; or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Medical Exemplant must be notified at once.	To	Melvin L. Hoy  19a. Informant's Name/Relationship (Type Laura Haberkir)  20a. Method of Disposition  1 Burial 2 October (Specify)  21. Signature of Funeral Service License	moval from State Lee	2731 se of Dispo detery, crer Crem	Grevete esition (Name of matory or other p atory	et and Number or Ru  n St . Ale lace) Feb. 2000	xandria  Date  Functa	City or Town, State.  Virginia 2  20c. Location - City of  Clinton, N  1 Home, Ir	2306 r Town, State lary Land
bhysician be executed / Medical Examiner and bhysician and sthe burial-transit		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequent of the to	nce of):	er the mode of d	1 1	or respiratory arre	est,	Approximate Interval Between Onset and Death
ath certific	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	ic. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3[	□Ectopic pregnar □ Other (specify)			23d. Date of d Month	elivery Day Year
w requires that the debeen signed by the a	ğ	Part II. Other significant conditions con	tributing to death but not result	ing in the u	inderlying cause	given in Part I.	23e. Did tol		to the cause of death?  Probably 4 Unknown
The law recate has be cate has be	Completed							med? prior to death'	autopsy findings available o completion of cause of case 2 No
To the Hospital or Attending Physician: The law requires to within 24 hours after death.  To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be to	ation: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		P/Outpatie 8b. Time o Injury	of 28c. In	Other: 4 Nursing H		ence 6 Other (Spow injury occurred	pecify)
LIVISIR Ital or Attending after death ral Director: led in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)				City or Tow		
Lothe Hospital Within 24 hours a To the Funeral is completely filled	Medical	29a. Certifier (Check only one)  29b. Signature and title of certifier	ician: To the best of my knowler: On the basis of examination and manner stated.	ledge, deat on and/or in	nvastigation, in m	e time, date and place by opinion, death occu ense number	irred at the time, o	ause(s) and manner date and place, and d 29d. Date signed (Mo	ue to the cause(s)
) 5.35.8		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type	Print)	1396	91	2/6/	Tomph His
	tate	31. Date filed (Month, Day, Year)		E	446	7 old	Brnu	6 MUC	1 onfu H.
Regis		FFB 1 5 200	6 Astrono St	400	SAEL				

			1 - For State Registrar	State of Ma	aryland				ealth a Death			giene	000		14238
	Dhusiai		1. Decedent's Name (First, Middle, Last)								2. Date of De				3. Time of Death
	Physici /Medic		Michael Wayne A	ustin							FEBRUA	ARY 1	1, 200		6:13Рм
	Examin		4a. Facility Name (If not institution, give s Saint Joseph	street and number)	Cen	ter	4b. City,	Town, or	Location o	Death	on	4c.	County of D		.more
			Social Security Number     6. Sex				If Under	1 Vear	If Under						
	Funeral Director			1M 2 0 E	43	st birthday) Yrs.	Months		Hours	Min.	8. Date of Bir (Month, Da April	th y, Year) 13 10	9.1	Country	e (State or Foreign yland
			Usual Residence of Decedent		7.7						Whili	10,1	702	riai	yrand
	how		10a. State 10b. County		10c. City,	Town or Lo	cation							10d.	Inside City Limits
	e Ma	cto	Maryland Harfor	rd		Py.	lesvi	11e			-				1 ☐ Yes 2X No
	or 2	Director	10e. Street and Number				10f. Zip	Code				10g. Citi	zen of What	Country	?
	23s	Fal	1614 Scott Road	10 111- 01-1	F	101			132				U. S		
	ter de	Funeral	11. Marital Status  1 ☑ Never Married 2 ☐ Married	12. Was Decedent if Armed Forces?		). 13. V	f Yes, spe	offy Cuba	ispanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - A Black, W		
ဗ္ဗ	urs af	by	3 Widowed 4 Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	10		1 🗆 Yes	2∏ No	Specify:				Specify:	Whit	.0
Ö	within 72 hours after death with the Maryland ene. then "netural", or itame 23a or 28a-f ehow fra Madical Exaction must be notilled at	Completed	15. Decedent's Educ	cation		16a. Deced	dent's Usua	al Occupa	ation	A - 4 4	· .	16b. Kii	nd of Busine		
7	ithin 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. L	DO NOT u	se retired,	turing mosi )	t of worki	n <i>g</i>				
7	ygien ygien yer th	Con		5 +		Faci	litie	s Su	pervi				on Un	iver	sity
ğ	be fill	Be	17. Father's Name (First, Middle, Last)								(First, Middle		Sumame)		
⋛	hould d Mer marke matic	2	Everette Austin,  19a. Informant's Name/Relationship (Type			ton Maille		(0)			Burnet			7: 0	
Maryland 21215-0036	d 2 s th an th an t7 ie r		Doris Austin (Moth								N Route Numb				
ē,	Heal Heal tem 2		20a. Method of Disposition	101)	20b. Pla	ace of Dispo metery, cren					ate )		cation - City		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Deportment of Health and Mentel Hygiene. Deportment of Health and Mentel Hygiene. The marked other than "natural", or itame 23a or 28a-f show any injury or other traumatic event, the Medical Examinating the notified at Once.	3	1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		metery, cren yview				2/14.	/2006	Balt	imore.	Mai	ryland
릁	mit. Joortan		21. Signature of Funeral Service License	90 / //											f Bel Air
m	Deperming Deperming Many in page 2000		Made			Inc	c.,61	0 W.	Macp	hail	Rd.,	Bel A	Air, M	d. 2	1014
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death.	Do not ente	er the mod	e of dying	g, such as	cardiac o	or respiratory a	rrest,		Ap	proximate terval Between
	Physician		Immediate Cause (Finat disease or condition	ACUTE	MYO	CARDI	IAL :	INFE	ARCTI	ON					nset and Death 24 HOURS
	/Medical Examiner		resulting in death)	Due to (or as		,	2 27 1 1 1	netty garans						.~	
П	-X011111C	-	Sequentially list conditions, b.	ACUTE			41 F U i	7E						1	4 HOURS
$\mathcal{F}$	nsit	nlne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	HYPER	'		CODI	A T COM	YOPE	TUV					'EARS
Ć.	execu in and ial-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a			CHIN	7 1 (3)	HWEE	71111				-	La PH ( w)
8760,	icate be executed physicien and s the burial-transit	dlcal	<b>€</b> d.												
		Med	IF FEMALE:												
Вох	leath certific ettending p	lan/I	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth	2 Fetal c	death 3	lEctopic pr	egnancy				2	3d. Date of o	delivery Da	y Year
o <u>.</u>	The law requires thet the death certific sie has been signed by the ettending r bage 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of dea	ath 5⊡	Other (sp	өсіfу)					MONIT	Da	y i eai
۳.	res thet the de igned by the e be detached t		Part II. Other significant conditions con	tributing to death bu	ut not result	ting in the ur	nderlying c	ause give	n in Part I.		23e. Did t	obacco us	se contribute	to the c	ause of death?
ds	n sign	d by									10	Yes 2	⊇No 3□	Probably	y 4 ∐Unknown
000	s been s	lete									24a, Was	an	24b. Were	autonsv	findings available
Division of Vital Records,	Physician: The lav r this certificate has ral director, page 2 :	Completed							. <u> </u>		autor perfo	rmed?	prior 1 death 1 ☐ Y	o compt	etion of cause of
<u>ta</u>		BeC	25. Was case referred to medical examiner?						26. Place	of Death	Check only	24 No			7140
<u></u>	hysic his ce I dire	၉	1 ☐ Yes 2 No	ospital: 1 📉 Inpatier		R/Outpatient	1 3 □ DC	A Othe	4 🗆 Nui	rsing Hor	ne 5□Resi	dence 6	□Other (S	pecity)	
<u> </u>	i or Attending Physician: aftar death. Director: After this certifica i in by the funeral director,	on:	27. Manner of Death 1 X Natural 5 □ Pending	28a. Date of Injur (Month, Day	Year) 2	28b. Time of Injury		8c. Injury Work			28d. Describe	how injury	occurred		
<u>s</u>	death death ctor: / y the f	icat	2 Accident investigation 3 Suicide 6 Could not be	One Diese of laiv			М		/es 2 □ !	-	20/1 /	•			
<u>&gt;</u>	i g ta o	Certification;	4 Homicide determined	28e. Place of Inju building, etc	: (Specify)	ne, rarm, stre	et, factory	, опісе		· ·	28f. Location (3 City or To	wn, State)	Number or	Hurai Ho	oute Number,
	To the Hospital or within 24 hours aftro the Funerel Discompletely filled in	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	er: On the basis of	examinatio	ledge, death on and/or inv	occurred estigation,	at the time	e, date and	d place, a	and due to the ed at the time,	cause(s) date and	and manner place, and d	as state	d. e cause(s)
	omple	Mec	29b. Signature and title of certifier	and manner sta				License					signed (Mo		
	- s - o		> CM/my E. Jull	M.D.				D 3	88570	4			12/2		
	v0	1	30. Name and address of person who cor	mpleted cause of de	eath (Item 2	23a) (Type, I	Print)					4	, -		~
	IU		JEFFREY E. SEL	L. M. D.		01 09	SLER	DRI	VE.	TOW	SON, I	MARY	LAND	218	2014
	Sta Registra		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	ire	last.								

DHMH 17 Rev 1/2001

			1- State of Maryland / D		irtment of tificate o		nd Mental H	ygien Reg. N	0000	04239
	Physici /Medio		1. Decedent's Name (First, Middle, Last) Paul Willard Adkins				2. Date of D Month Febru	Death WY	14, 2006	3. Time of Death 7:44 Å M
	Examin		4a. Facility Name (If not institution, give street and number) 4944 Brightleaf Cowrt			, or Location of Ltimore	Death	4	c. County of Death Baltimor	h
I	Funeral Director		70	hday) (rs.	If Under 1 Yea Months Day		Min. 8. Date of E Month, I July	Birth Pay, Year	9. Birtl 1915 VV	hplace (State or Foreign untry) LGUNA
	aryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Loc	cation					10d. Inside City Limits
	he Ma 28a-f s	Director	Maryland Baltimore	B	altimor					1 ☐ Yes 2 No
	3a or	i Dir	10e. Street and Number 4944 Brightleaf Court		10f. Zip Code	21237		10g. C	itizen of What Co U.S.A	*
	r death	Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?	13. V	Vas Decedent of Yes, specify Cu		in? (Specify Yes or N Puerto Rican, etc.)	10-	14. Race - Ame Black, White	ncan Indian,
0000	ral', or l	þ	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No 3 ☐ Widowed 4 ☐ Divorced 1 ☐ Yes, Give Year or Dates:		☐Yes 2XN				Specify: Wh	
ה	in 72 h	Completed	(Specify only highest grade completed)	Decede (Give I	lent's Usual Occ kind of work don OO NOT use reti	cupation ne during most (red)	of working	16b. I	Kind of Business/l	Industry
7 7	od withi giene. er than	Somp	Elementary/Secondary (U-12)   College (1-40f 5+)		Worker			Be	thlehem:	Steel
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland orderinent of Health and Mental Hygiene. Ordent: If item 27 is marked other than "natural", or Items 23a or 28a-f show injury or other traumatic event, the Medical Examination in the Excellist at 18.9.	To Be (	17. Father's Name (First, Middle, Last) Wilson Adkins			18. Mother	's Name (First, Midd Ly Pri		n Sumame)	
Mary	12 shouh and N 7 is mar traumat	-					or Rural Route Num Bel Air, 1			(ip Code)
e,	of Healt of Healt item 2 r other		20a. Method of Disposition 20b. Place of	Dispos	sition (Name of natory or other p	1	Date Date	-	I U I 4 Location - City or	Town, State
allillor	permit. Pages 1 a Department of Hez Important: If Item any injury or othe		*4 □ Donation 5 □ Other (Specify) Oak Law	on (	Cemeteri	y 2	/18/2006	Ba	ltimore,	Maryland
סמ	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee	9	Name and Add	iress of Facility Liv Rd.	Schimune, Baltimo	k Fui re. N	reral Hor ND 21236	mes
			23a. art1. Enter the disease, or complete one that caused the death. Do no shock, or heart failure. List only one cause on each line.			ying, such as c	cardiac or respiratory	arrest,	,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence or	-la	butley	2 pm	liveway of	هيا	ierel	many yles
	Examiner	<u>.</u>								
V	d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Ento Underlying Cause (Disease or injury that initiated events	1):						
,007	cate be executed physician and the burial-transit		resulting in death) Last Due to (or as a consequence of	f):						
0	tificate ng phys as the	ledicai	d							
ממ	leath certific attending p	ician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death		Ectopic pregnar	псу			23d. Date of deli	very Day Year
5	that the de led by the a detached i	hys	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 9 ☐ Unknown	5	Other (specify)					
colds, r	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	ed by P	Part II. Other significant conditions contributing to death but not resulting in	the un	derlying cause of	given in Part I.		Yes 2		the cause of death?
2	e law re has bee e 2 sho	ompieted					24a. Wa	opsy	prior to c	topsy findings available completion of cause of
ונמו ב		e Cor	25. Was case referred medical				1 ☐ Yes		o death? o 1 ☐ Yes	2 □ No
<b>-</b>	Physician: this certific ral director,	To B	examiner?  1   Yes 2   No	patient	3 DOA	Nu	of Death (Check only sing Home 5		6 □Other (Spec	eify)
	inding Plath. r: After the funeral		27. Manur of Death  1 Natural 5 Pending 2 Accident investigation  28a. Date of Injury (Month, Day Year)  Injury	ime of jury		jury at /ork? □ Yes 2 □ N	28d. Describe	a how inju	iry occurred	
	al or Atter de safter de l'Directo	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	m, stre	eet, factory, offic	е		(Street a own, Stat		ral Route Number,
	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	edical (	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medicel Examiner: On the basis of examination and and manner stated.	death Vor inv	occurred at the estigation, in my	time, date and opinion, death	place, and due to the	e cause(s	s) and manner as id place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and vitle of certifier	7	29c. Lice	nse number	660	29d. Da	ate signed (Month	n, Day, Year)
	10		30. Name and address of berson who completed cause of death (Item 23a) (1			10 79	0,0	1	107/	
	(V Sta	to	Dr. Jeffrey A. Cool, 5009 Honeygo  31. Date filed (Month, Day, Year)  31. Registrar's Signature	Ce	nter Dr	.,Suite	2 216, Per	ry H	all, MD	21128
	Registr		FEB 1 5 2006	23	MC.					

			1 - For State Registrar	State of Ma		/ Depa		t of H	lealth a	and M		iene	06	04240	
K.	\$ 120		Decedent's Name (First, Middle, Last)								2. Date of Dea	th		3. Time of Death	h
*, °	Physici /Medic		Louise Mars	1 Baile	e						Februra	ny 11	2006	4:15 F	M
	Examin		4a. Facility Name (If not institution, give s		1		1		Location of			4c. Cc	ounty of Death		
7.9		<b>*</b>	Union Memon						imo						
	Funeral Director		5. Social Security Number 6. Sex 217-22-5610  Usual Residence of Decedent	IM SKIE	(In yrs. Ia. 85	st birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day 12/05/1		9. Birth Cou Mary	place (State or Fore ntry) 1and	ign .
	land ow		10a. State 10b. County		IOc. City,	Town or Lo	cation							10d. Inside City Lim	nits
	Man Frah	ţō	Maryland		-	Balti	more							1 X Yes 2 □	No
	or 28g	lre	10e. Street and Number				10f. Zip	Code			1	0g. Citize	n of What Cou	ntry?	
	23a ust b	Funeral Director	4050 Hillen Road					2121	8			U.	S.A.		
	r deg	Jue	11. Marital Status	12. Was Decedent Ev Armed Forces?		. 13.	Was Deced	ent of Hi	ispanic Ori	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Ameri Bfack, White,		
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 【XNo If Yes, Give			1 ☐ Yes 2	2 <b>X</b> No	Specity:			Sp	pecify: B1	ack	
8	hour	ed	15. Decedent's Edu	Year or Dates:		16a Dece	dent's Usua	Occup	ation			16h Kind	of Business/Ir	ndustry	
15	n n	plet	(Specify only highest grade	e completed)		(Give	kind of wor DO NOT us	k done d	during mos	t of worki	ng	.00. 11110	01 0 0011103011	idadiiy	
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. sther then "neturel", or Iteme 23a or 26a-f show ont. Ite Madical Examiner must be notilied at	Completed	Elementary/Secondary (0-12)	Colfege (1-4or 5+		Bal	ker					В	Bakery		
פ	al Hys	Be	17. Father's Name (First, Middle, Last)						18. Mothe	r's Name	(First, Middle,	Maiden Su	ımame)		
<u> a</u>	Ments Ments arked arice	10	Arthur Hamilton						Car	rie	Nolan				
lan.	and and ls ma		19a. Informant's Name/Relationship (Ty	pe, Print)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	il Route Number	; City or T	own, State, Zij	o Code)	
2	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Itame 23a or 28a-f show any Injury or other traumatic event. It a Modical Examinat must be notified at once.		Laurence Bailey		anh Die	4050	H111	en R	oad,	Balt	inore				
Ore	ges 1 t of H if Ite or ot		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ R	lemoval from State	cer	ce of Dispo netery, crer	natory or o	ne or ther plac	e)		Date	20c. Loca	tion - City or T	own, State	
Baltimore,	t. Pa tmen tent: ijury		4 □ Donation 5 □ Other (Specify)		Kin	g Memo								Maryland	_
Ba	Depa Impo any l		21. Signature of Funeral Service Licens											/H, P.A.	
			23a. Part1. Enter the disease, or compli	ications at caused the	ne death.								, Mary	land 2121 Approximate	
			shock, or heart failure. List only or Immediate Cause (Final	ne cause on each line				-	-		,	,		Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)	Due to (or as a				, 0(1	,					one da	4
22	Examiner				301100440	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,									
	BILLEGA	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	conseque	ence of):									
6	cuted	Examiner	that initiated events	o											
. 1092	ate be executed hysicien and he burial-transit	Ä	resulting in death) Last	Due to (or as a	conseque	ence of):									
876	cate b	dlcal		J				<u>_</u>							
× 68	ding p	Physician/Med	IF FEMALE:	3c. If yes, outcome of	nregnand	~v									
Bo	atten for u	clan	in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at ti	☐ Fetal d	leath 3	Ectopic pro					230	d. Date of deliv Month	ery Day Year	
o.	the d y the iched	ysl	1 ☐ Yes 2 St o 9 ☐ Unknown	9☐ Unknown		5	2 011101 (0)								
Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica rr death.  ector: After this certificate has been signed by the attending ph by the funeral director, pege 2 should be detached for use as the	by Pi	Part II. Other significant conditions con	ntributing to death but	not result	ing in the u	nderlying ca	ause givi	en in Part I.		23e. Did to	bacco use	contribute to t	he cause of death?	1
g	quire an sig uld bu	ed b	Hypertension	, try pe	rlip	der	MIR				1 🗆 Y	es 2 🗆 1	No 3 Pro	bably 4 □Unkno	wn
000	awre is bee	plet	Hypertension Chronic Obst	nuctive	Pa	lmor	rary	Di	seas	و_	24a. Was a		24b. Were auto	opsy findings availa	ible
m m	The I	Completed									autops perfori 1 Yes		death?	mpletion of cause of 2 No	OI.
ita	ian: artifica ctor, j	Be	25. Was case referred to medical examiner?	WORTHS .					26. Place	of Death	Check only or				
× ×	hysic his ce il dire	2	1 □ Yes 2 □ <b>½</b> e	lospital: 1 🔲 Inpatient	2	P.Outpatier			4 LI NU	rsing Ho	ne 5 🗆 Reside	ence 6	Other (Speci	fy)	
Ē	ing P	ü.	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		8b. Time of Injury		8c. Injun Worl			28d. Describe h	ow injury o	ccurred		
Sic	ttend death tor: /	cat	2 Accident investigation 3 Suicide 6 Could not be	20a Place of fairing	. At how		M		Yes 2 🔲		20f Location (C	trant and A	dumber of Ove	al Cauta Numbas	
Division of	after a	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	ie, iaim, str	eet, ractory	, OITICE		'	City or Town		valider or Aur.	al Route Number,	
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, pege 2		29a. Certifier X Certifying Physical Check only 2 Medical Exami	sician: To the best of	my know	ledge, deatl	h occurred	at the tin	ne, date an	d place, a	and due to the c	ause(s) an	id manner as s	stated.	-
	the H nin 24 the Fi	Medical	one)	ner: On the basis of e	d.	AT ALTOVOR IN				ui occurr					
	To the within 7 To the comple	Σ	29b. Signature and title of certifier	PN P	_ 0		290	. License	e number		ء ا	9d. Date s	signed (Month,	Day, Year)	1.
,	_		Zelyance	V. 15	2	>			- ا در	م د د الما	1-01	epn	m uny	15,200,	Ø
	7		30. Name and address of person who co	mpleted cal of dea	th (Item 2	3a) (Type,	Print) E	27)	abel	nd.	21117				
1	Sta	to	31. Date filed (Month, Day, Year)	32. Registrar			1037	7 (4)	Ju	- (4	01117	-			
	Registr		FEB 1 5 2		- N	J. A	ande	F							

134	<u>′</u> +		. 10400						nd Mental F		Legible.		
			for State Registrar	Oldio of IV	iai yiai	-	rtificate of		ing mornari	Reg. No.	IIIIn	042	
	Dharini		1. Decedent's Name (First, Middle, La	ist)			-		2. Date of	Death		3. Time of	
	Physici /Medio			Thomas	Α.	Brook	s		FEBRU	ARY T	3, 2006	1321	Рм
	Examir	ner	4a. Facility Name (If not institution, gir 2010 N. DUKELAND		")		4b. City, Town, o		Death	4c.	County of Dea	ith	
	Funeral Director			Sex 7. A X M 2 □ F	ge (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 2	Min. (Month,	Birth Day, Year)	9. Bii	rthplace (State ountry)  Md	or Foreign
3	3.		Usual Residence of Decedent  10a. State 10b. County			ty, Town or Lo	cation					10d. Inside C	ity Limite
1215-0036	-f sho	tor	Md	N/A		Balto						1	2 🗆 No
1 1	or 28a	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What C	ountry?	
-	238	rai	2010 N.Dukela	nd Street			W	21216			S A		
1		nue	11. Marital Status	12. Was Deceden Armed Forces	?	J.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origi an, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Am Black, Whi</li> </ol>		
36	l', or l	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2▼ If Yes, Give Year or Dates:	] No		1 ☐ Yes 2 ☐XNo	Specify:			Specify: I	Black	
Ö i	atura	ted	15. Decedent's E	ducation		16a. Dece	dent's Usual Occup	pation	-1 - 1 -	16b. Ki	nd of Busines	s/Industry	Unk
2	Med	Completed by Funeral	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	5+) N/A		kind of work done DO NOT use retire gshorema:		or working				JIIK.
72	ther ti	S	11th grade 17. Father's Name (First, Middle, Las	()	N/F	д поп		1	's Name (First, Mio	dla Maidan	Sumamo)		
Maryland 21215-0036	permit. Fages I and 2 should be lifed within 72 flouts after beauti with the marylar limportant of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent, the Medical Examinar must be notified at once.	To Be	James M. Brooks			. •			nie Holl $\epsilon$		Surrante		
Mary	n and h	ľ	19a. Informant's Name/Relationship Howard Brooks -	• •		1	-		or Rural Route Nu Balto, Mc			Zip Code)	
ē.	Heelt tem 2		20a. Method of Disposition	3011	20b. I		isition (Name of natory or other pla		Date Date		ocation - City o	r Town, State	
Baltimore,	rages nent of int: If its iry or o		1 SpBurial 2 ☐ Cremation 3 [ 4 ☐ Donation 5 ☐ Other (Speci		3		natory or otner pla orial Pa	1	17-2006	Ran	dallsto	own, Md	
<u>a</u>	Departri Departri Imports any Inju		21. Signature of Funeral Service Lice	nsee /		22	. Name and Addre			6.15	West		
Ш	10 5 4 9		Tyrette	K. Jm	6				sh Avenue		to,Md 2	T	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each	line.					y arrest,		Approxima Interval Be Onset and	tween
7	hysician /Medical		disease or condition resulting in death)	a. ARTERIOS Due to (or a			ARDIOVASO	CULAR I	DISEASE			-	
E	xaminer		Sequentially list conditions	b									
/ 3	nsit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a consec	quence of):							
ó	ie be executed ysician and ie burial-transit	Exar	that initiated events resulting in death) Last	Due to (or a	s a consec	quence of):							
		dicai		d								_	
89 x	dingp	/Mec	IF FEMALE:	23c. If yes, outcom	e of prean	ancv					and Data of de	li.	
മ	a atten	ician	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	1☐Live birth 4☐Pregnant a	2 Feta	al death 3	Ectopic pregnanc Other (specify) _	у			23d. Date of de Month		Year
0	by the	Physician/Med	9 Unknown	9□ Unknown									
Division of Vital Records, P.O. Box 68	n signed uld be de	by	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying cause gr	ven in Part I.				to the cause of a	
9	has been si ge 2 should	Completed							24a. V	ras an utopsy	24b. Were a	utopsy findings completion of c	available
<u> </u>	uning Priyecterit. The h.								1 □ Ye	erformed? s 2 No	death?	s 2□No	
	s certifi irector	o Be	25. Was case referred to medical examiner?  1 Xes 2 No	Hospital: 1 ☐ Inpat	ient 2	ER/Outpatier	nt 3 DOA Ot		of Death (Check or sing Home 5 ☐ F		c <b>Y</b> ion (C-	ecity) SCEN	E
ם ר	ter this	n: To	27. Manner of Death	28a. Date of Inj	jury	28b. Time o	" 30 DOX	4 🗀 Nuli		be how inju		вспу) ССТТ	
sloi	eath. or: Af the fur	catic	1 Natural 5 Pending 2 Accident investigate 3 Suicide 6 Could not l	on			M 1	Yes 2 □ N	lo				
Div	5 th 25 E	Certification	3 ☐ Suicide 6 ☐ Could not l 4 ☐ Homicide determined	200. Place of it	njury - At h etc. <i>(Speci</i>	ome, farm, str fy)	eet, factory, office			n (Street an Town, State		Rural Route Nun	nber,
	within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 Certifying P	hysician: To the bes miner: On the basis	t of my kno	owledge, death	n occurred at the ti	ime, date and	I place, and due to	the cause(s)	and manner a	is stated.	e)
1	thin 24 tha F mplet	Med	29b. Signature and title of certifier /	and manner s	stated.		29c, Licen				te signed (Mor	`	-,
)	- ≯ ∓ 8			w/V	$V\setminus$			OCME		1		3, 2006	
	li.		30. Name and address of person who	completed use of	death (Ite	m 23a) (Type,	Print)						
	٧/		31. Date filed (Month, Day, Year)	1/1/V	trar's Sign			ET, BAI	LTIMORE,	MARYL	AND, 21	201	
	Regist	ate rar	31. Date filed (Month, Day, Year) FEB 1 5 2	006		ature	outed.						

Alan T. Bush 06-01078 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f,pen/H,G852,2/22/06 TI State of Maryland / Department of Health and Mental Hygiene Reg. No. UUG Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** ALAN THURMAN BUSH <u>1:15</u> Р <sup>м</sup> February 11 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4126 East Joppa Road Nottingham Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 11-10-1948 9. Birthplace (State or Foreign **Funeral** 219-52-8232 **№**М 2□ F 57 Yrs. MARYLAND Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location or 28a-f ehow 10d. Inside City Limits ir than "natural", or items 23a or 28a-f eho the Medical Examinar must be notified at 1 Yes 2 No MD BALTIMORE PARKVILLE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9905 MAIDBROOK ROAD 238 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married MXYes 2 □ No If Yes, Give Year or DatesVIETNAM Baltimore, Maryland 21215-0036 1 Yes XXNo þ Specify: Specify: WHITE 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Cottege (1-4or 5+) JOURNEYMAN ELECTRICAL 12 other 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth any injury or other traumatic event 9DR8. 18. Mother's Name (First, Middle, Maiden Sumame) Be RAYMOND T. BUSH HELEN (GNACYK) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROSE BUSH/ WIFE 9905 MAIDBROOK ROAD PARKVILLE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PARKWOOD CEMETERY 1-17-2006 PARKVILLE, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facilit CVACH/ROSEDALE FUNERAL HOME ROSEDALE, MD 1211 CHESACO AVENUE 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** a Acute alcohol intoxication complicated by hypothermia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 ician/Medicai the IF FEMALE: 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f Physi Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ cete has been signated bage 2 should b 2 (24)0 1 Tes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Ves 2 No autopsy performed? 2 No 25. Was case referred to medical director Be 26. Place of Death Check only one examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene 1XXYes 2 No P 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Subject living Certification: 28c. Injury at Work? 1 Natural

Hospital or Attending Physician: The law requires that the death certificate be executed After filled in by the f hours after within 24 hours a

5 Pending investigation Fnd 2/11/06 1 ☐ Yes 27 No 2 🗓 Accident Fnd 1:09 P in pick up truck with no heat and 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4126 East Joppa Rd. 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Found in pick up truck 4 Homicide Nottingham, Mi 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

29b. Signature afid

29c. License number OCME

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) February 13, 2006

30. Name and address of person who cor plet cause of death (Item 23a) (Type, Print)

111 Penn Street Baltimore, Maryland 21201

State Registrar

Medicai

31. Date filed (Month, Day, Year) FEB 1 5 2006

one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item: 8, per State of Maryand 23 epartment of Health and Mental Hygiene 06243 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Physician Month Bailey 0515 AM Cann February Caroline 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NA Baltimore Union Memorial Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 5 / 2 9 / 2 49. Birthplace (State or Foreign (Month, Day, Vear) 9 / 2 49. Birthplace (State or Foreign **Funeral** 1□M 2□ 81 Yrs. Director 217-20-7611 5-20-24 Md. Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show the Medical Examiner must be notified at 1. Yes 2 No Funeral Director Baltimore Md. NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21229 712 Allendale Street 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 2 should be filed within 72 hours after a and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Other Peoples Homes Domestic 8th grade permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any njury or other treumatic event 2028. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Elizabeth Lindsay Cann Geroge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 712 Allendale Street, Baltimore, Md. Daughter Brenda Bailey 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-06 Randallstown, Md. King Mem. Pk. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. March F.H. East 1101 E.

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1101 E. North Ave. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUO Cardia hour /Medical Due to (or as a consequence of): Examiner OFONAT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner anding physician and use as the burial-transit STENS10 resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical been signed by the attending should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 🗌 Inpatient 2 ER/Outpatient 3X DOA 1 Yes 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 ☐ Accident 5 Pending death. 1 ☐ Yes 2 ☐ No investigation filled in by the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide To the Hospital within 24 hours a To the Funerel Completaly filled in 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Alle of certified 29c. License number 29d. Date signed (Month, Day, Year)

n

State Registrar 201 & University 7 Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

5

Hospital

32. Registrar's Signature

D0053373

Paul Kong

February 12, 2006

Amend Item 18 per 18 per 18 per 19 ges 22-15-06 vt.

State of Maryland / Department of Health and Mental Hygiene
Amend Item#2 per PHY G853 3/1/06 CC difficate of Death

Reg. No.

2. Dete of Death 2/12/06
Month Deey Year

		Amend Item#2 po	EL LHI CODD 3	Certificate of	f Death	Reg. No.	00 04244
		1. Decedent's Name (First, Middle, La				2. Dete of Death 2/12	
	Physician	Elsie		Brown		Month Dey	2:05 Am
	/Medical Examiner	4e Fecility Neme (If not institution, giv	e street end number)	13	4b. City, Town, or L	ocetion of Death 4c. Cou	unty of Deeth
	LAdimire	Keswickmun	TCARE CI	ENGL	BATTIN	LORE BA	priore City
	Funeral	5. Social Security Number 6. S		rs. last birthday) If Under 1 Ye	ar If Under 24 Hrs.	8. Date of Birth (Month, Dey, Yeer)	9. Birthplace (State or Foreign
	Director	219-22-1895 1	□M 2/20 F	9 / Yrs. Months Day	ys Hours Min.	(Month, Dey, Yeer) MARCH 17, 191	4 MARYLAND
	100	Usuel Residence of Decedent				MARCHIGITI	1 / / / / ZANO
	ylane 30w	10a. Stete 10b. County	10c.	City, Town or Location		_	10d. Inside City Limits
	Mar Mar	MARYLAND N	10	BA	TIMORE	CITY	1√ Yes 2 No
	er death with the Marylar flems 23a or 28a-f show ner must be notified at uneral Director	10e. Street end Number	///	10f. Zip Code	9	10g. Citizen	of Whet Country?
	3a o	24.50 11)50	T COLLEGE	10 lAUE	-212	is	1150
	Jeath Tree 2	11. Maritel Stetus	12. Was Decedent Ever in	U.S. 13. Was Decedent of	of Hispanic Origin? (Spuban, Mexican, Puerto	ecify Yes or No- 14. I	Race - American Indian,
_		1 ☐ Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 💢 No			Rican, etc.)	Black, White, etc.
21215-0020	urs aff	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Yeer or Dates:	1 ☐ Yes 2 ☑ N	to Specify:	Spe	ecity: BI AN. N
Ą	ad within 72 hours ygiena. Per than "natural", it, tre Medical Exi Completed by	15. Decedent's Ed		16e. Decedent's Usual Occ	cupation	16b. Kind o	f Business/Industry
75	Z nin Z	(Specify only highest gre		(Give kind of work dor life. DO NOT use ret	ne during most of work ired)	ing	
3	iena tha Om	X +++ C-D A-DE	College (1-4or 5+)	CARC	1 FANIF	0 BAN	RAILROAD
	be filad ntal Hygin of other event, the Cc	17. Father's Neme (First, Middle, Last)		-///	18. Mether's Nam	e (First, Middle, Maiden Suri	name)
au	Mantal H Marked oth artic even	11/11/120		Th Halend	Henrie	LLA	JO HNSON
Maryland	d 2 should th end Mar 7 is marke traumatic	19a. Informant's Name/Relationship	Type Print)	19h Mailing Address (Stre	et and Number or Bur	al Route Number, City or To	
Z Z	d2s ther 7 is trau	ELSIE & Och	- (	21112 54	1015114	1/57 Che si m	
	f Heal fem 2 other	20a. Method of Disposition	E DAUGHTE	o. Place of Disposition (Name of	IKLEY	Date 20c. Location	on - City or Town, State
Baltimore,	0 0 L L	1 Burial 2 □ Cremation 3 □	Removal from State	cemetery, crematory or other p	,	1000000	on - City of Town, State
Ë	permit. Pag Department Important: f any injury o pnee.	4 Donation 5 Other (Specify	0 A	RBUTUS CEN	ETERY	2-17-06 ARBI	ITUS MARYLANI
a	permit. Pa Departmar Important: any injury once:	21. Signature of Funeral Service Licen	see '	22. Name and Add	ress of Facility	OWN TR. FG	INEXAL HOME B, MD 21217
ш	201	1 ) which	11, 1x Illean	mo 2140 N	FULTON	AVF. BALTO	3, MD 21217
		23a. Part1. Enter the diseese, or companies shock, or heart failure. List only	plications that caused the de				Approximate Interval Between
No.	Physician	snock, or neart failure. List only	one cause on each line.				Onset and Death
	/Medical	Immediate Cause (Final	1 . (	01	- 4	_	
150	Examiner	disease or condition resulting in death)	a. Schen	nic Cardio	myopar	ry	weeks
5	e le		Due to	o (or as a consequence of):	U		i
1	ficeta be executed a physician end is the buriel-transit edical Examiner		b				
_	end end si-tra	Sequentially list conditions, if any, leading to immediate	Due to	(or as a consequence or):			
68760,	entificeta be executed ting physician end se as the buriel-transit	cause. Enter Underlying Cause (Disease or injury that initiated events	c				1
82	phys the	resulting in death) Last	Due to	(or as a consequence of):			
×	ding se es		d.				
Bo	es that the death c igned by the attent be detached for us by Physician						
o	the a	Part II. Other significant conditions of	ontributing to death but not r	resulting in the underlying cause	given in Part I.	23b. Did tobacco use	contribute to the cause of death?
<u>о</u> .	at the	Hyper tensing	woheasel	erosil		1 ☐ Yes 2 N	o 3 Probably 4 Unknown
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Records,	The law require cata has been si page 2 should Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to
ပ္တ	aw re is be 2 sh						completion of cause of deeth?
ď	he la ta ha age					1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No
ā	entifical actor, p	25. Was case referred to medical			26 Plece of Deat	(Check only one)	
>	Attending Physician: or death. ector: Aftar this cartific by the funeral director, iffication: To Be (	evaminer?	Hospital:	□ ER/Outpatient 3□ DOA	NI 4	me 5□ Residence 6□(	Other (Canaily)
ō	Phy oral o	27. Manner of Death	28a. Date of Injury			28d. Describe how injury occ	
S O	Afta fune	1 Natural 5 ☐ Pending	(Month, Dey Year)		jury at / fork? ☐ Yes 2 ☐ No	,,,,,,,,,,,	
S	death death stor: / y the f	3 Suicide 6 Could not be		t home, farm, street, factory, offic		28f Location (Street and Nu	mber or Rural Route Number,
Division of Vital	tal or Attending Pins after death.  al Director: After tiled in by the funera  Certification:	4 ☐ Homicide determined	building, etc. (Spe			City or Town, Stete)	inder of ridial ridule redinder,
_	ottal C		The Table 1				
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	(Check only 2 Medical Exam	iner: On the basis of exami	nowledge, death occurred at the ination and/or investigation, in my	time, date and place, a opinion, death occurr	and due to the cause(s) and ed et the time, date and plac	manner as stated. e, and due to the cause(s)
	thin 2 the mple	one)	and manner stated.	200 1:	nco numbo-	004 0-4-1	and Month Day Versi
	S Š Š Š Š	29b. Signature and title of certifier	1		nse number	-	ned (Month, Day, Year)
	1	Villand	uns	D 5	8303	tebru	ary 13 2006
	10	30. Neme end address of person who o	completed cause of death (It	tem 23e) (Type, Print)			->/
	0	AAWN CHARLI	RS, ND 66	OIN Charles	It BARI	none no 21	204
	State	31. Date filed (Month, Day, Year)	32. Registrer's Sig				
	Registrar	FEB 1 5 2	2006	nature			
		1 Bel Mr -	The second secon				

State Registrar

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MDI

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ulcher

N. Charles Street/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month 1Zape Denjamin 2006 Christy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 50 Hospital ta/bor If Under 24 Hrs. 5. Social Security Number f Under 1 Year Birthplace (State or Foreign Country) Funeral 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 1 Hours Months 7-40-352 Director Yrs. Usual Residence of Decedent Pages 1 end 2 should be filed within 72 hours after death with the Maryland ment of Health and Mentel Hygiene. Bit of Health and Mentel Hygiene. Bit! I flem 27 is marked other than "natural", or Items 23a or 28a-f show bit! If learn 27 is marked other than "natural", or other traumatic event. The Maricial Experiment must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Nes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21226 Dence Completed by Funeral 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Yes, Give ear or Dates: ☐Yes fYes G Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1dth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be year 2 eorge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Son 4204 Washing ton Balto -any m. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Murial 2 ☐ Cremation 3 ☐ Removal from State 7-06 Woodlawn Woodlawn 4 □Donation SDOther (Specify) 22. Name and Address of Facility 21. Signature of Fyreral Service Licens FreditiLion 23a. Part Enferthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for hear failure. List only one cause on each line. Delto, md. 21229 Rineral Home Approximate Interval Between Onset and Death Immediate Cause (Final disease of condition resulting in death) **Physician** lentricular Fibrilla /Medical Due to (or as a consequence of): Examiner ocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien end for use as the burial-transit The law requires that the death certificate be executed CONATY Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical tension IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) this certificate has been signed by the a ral director, pege 2 should be detached t 9 Uakaowa 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2₽No funeral director, 25. Was case referred to medical examiner?

1 Series 2 □ No Medical Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation deeth. 1 ☐ Yes 2 ☐ No within 24 hours after deeth To the Funeral Director; / completely filled in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1)—Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, FEB

address of person who completed cadse of death (Item 23a) (Type, Point)

32. Registrar's Signature

			1 - For State Registrar	State of Mary		epartme Certifica				iene g. No.	06	04247
	Dhuaiai	\$	1. Decedent's Name (First, Middle, Last)						2. Date of Deat Month	h Dav	Year	3. Time of Death
	Physici /Medio		Sherman	Paisley	Во	one			Februar	T		6:05pm <sup>м</sup>
2 100	Examir	er	4a. Facility Name (If not institution, give s 301 Sherman Ave			4b. Ci	y, Town, or I Frede	Location of De rick	ath		unty of Death Tederi	ck
_:.	Funeral		5. Social Security Number 6. Sex	7. Age (In	yrs. last birthe		ter 1 Year	If Under 24 H	rs. 8. Date of Birth			place (State or Foreign
ū	Director		213-26-6213	M 2□F	74 Yr	s. Month	s Days	Hours M	May 17,	1931		yland
	and and		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town	or Location					1	Od. Inside City Limits
	Maryl	tor	Maryland Frederic	ck	F	rederi	ck					1 XYes 2 ☐ No
	h with the	Funeral Director	10e. Street and Number 301 Sherman Avenu	e		10f.	Zip Code	21701	1		of What Cour	ntry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Plygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Madical Examinating the Indilied at ODGE.		1   Never Married 2 Married	I2. Was Decedent Ever Armed Forces? 1 X Yes 2 □ No 1 If Yes, Give	.952-	If Yes, s	cedent of His pecify Cuban 2X No	panic Origin? , Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, ecify:	
Ö	hour	ed b	3 Widowed 4 Divorced		.953	ecedent's U	sual Occupa	tion		16b. Kind o	of Business/In	
21215	I within 72 liene. r than "na the M. allo	Completed by	(Specify only highest grade	College (1-4or 5+)	(6	Give kind of ife. DO NOT cords l	work done di use retired)	uring most of v	vorking		of Ene	·
Baltimore, Maryland 21215-0036	uld be filec fental Hyg rked othe tic event,	To Be C	17. Father's Name (First, Middle, Last) Sherman H	anson	В	oone		18. Mother's N Alma	lame (First, Middle, I	Maiden Sui Letta		Paisley
Mary	ind 2 shou aith and h 27 is ma ir trauma		19a. Informant's Name/Relationship (Type Paul W. Boone, Bro						Rural Route Number e, Jeffers			
more,	Pages 1 and of the out. If Item		20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ R: 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		crematory of	r other place				ion-City or To	own, State Mary Land
Balti	permit. Departn Imports any Inju	1 1	21. Signatury of Funeral Service License		0706	22. Name	and Address	Basfor	d P.A. Fu t, Freder	neral	Home Mary La	nd 21701
	Luyacian and // // // // // // // // // // // // //	Examiner	23a. Part1. Enter the disease, or complications, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cor	sequence of)	t enter the m	ode of dying	, such as card		est,		Approximate Interval Between Onset and Death
Box 68760,	n certificate be anding physici use as the bu	n/Medical	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pr		200				23d.	. Date of delive	ery
o.	that the death certific ed by the attending p detached for use as	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live birth 2 4 Pregnant at time 9 Unknown		3 □Ectopic 5 □ Other					Month	Day Year
rds, P	quires tha on signed l uld be det	ed by P	Part II. Other significant conditions con	tnbuting to death but no	t resulting in t	he underlyin	g cause give	n in Part I.	23e. Did tot	1.7		ne cause of death?
Division of Vital Records,	: The law requires that the death certific cate has been signed by the attending proage 2 should be detached for use as	Completed						-	24a. Was a autops perform	y		psy findings available mpletion of cause of
<u> </u>	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:			Othe	-	eath (Check only on			
o uc	ding Phys h. After this funeral di	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Recident investigation	28a. Date of Injury (Month, Day Yea	2 ER/Outp 28b. Tin Inju	ne of	28c. Injury Work	4 1 1401 21119	28d. Describe ho		Other (Specificurred	y)
Divisi	To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely illied in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Płace of Injury - building, etc. (Sp	At home, farm pecify)				28f. Location (St City or Town		umber or Rura	il Route Number,
	ne Hospit n 24 hours ne Funere	Medical C		ician: To the best of my ler: On the basis of exa- and manner stated.								
	To the To the Comp	Σ	29b. Signature and title of certifier	7/1		- 2	9c. License				gned (Month,	
)	^0		30. Name and address of person who co	mpleted cause of death	(Item 23a) (To	(E)	D371	L9/ 		ebru	ary 3,	2006
	30		Alan H. Rohrer, N	1.D. DME.	15 Wes	t Seve	nth Si	treet,	Frederick	, mar	yland	21701-4501
	Sta Registr	_	31. Date filed (Month, Day, Year) FFR 1 5 2006	32. Registrar's S	uyiiature	and I						

			State of Maryland / Department of Health and M  State Registrar  Certificate of Death		giene Reg. No.	04248
	Dhoraist		1. Decedent's Name (First, Middle, Last)	2. Date of De Month	aath Day Year	3. Time of Death
	Physicia /Medic Examin	al :	Frank Joseph Bucharewicz, Sr.  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death	02	13 2006 4c. County of Dea	
	Funeral Director	CHE	Stella Maris Hospice  5. Social Security Number  218-07-1748  Towson, Marylan  7. Age (In yrs. last birthday)  127 M 2 F  93  Towson, Marylan  15 Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Bir (Month, Da	Baltimo th ay, Year) 9. Bi 1912 Or	re rthplace (State or Foreign ountry)
	tryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	he Ma	Director	MD Baltimore Kingsville  10e. Street and Number 10f. Zip Code		40-01	1 ☐ Yes 21 No
$.^{M}.$ Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any injury or other traumatic event, Ite Medical Evarity at must be redified at ODEs.	by Funerai	10e. Street and Number  2 Upper Field Court  11. Marital Status 1 □ Never Married 3 □ Widowed 4 双 Divorced  10f. Zip Code  21087  12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼ No If Yes, Give Year or Dates:  10f. Zip Code  21087  13. Was Decedent of Hispanic Origin? (Specify Specify Cuban, Mexican, Puerto Types, Give Year or Dates:	pecify Yes or No Rican, etc.)	Specify:	encan Indian,
5-0	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ang	16b. Kind of Busines	
121	within ene. than	Completed	Elementary/Secondary (0-12) College (1-4or 5+) life. DO NOT use retired)		Dothlohom	Chaol Corn
<u>d</u> 2	filled I Hygin other	Be Co	12 Foreman  17. Father's Name (First, Middle, Last)  18. Mother's Name	e (First, Middle	Betnienem , Maiden Sumame)	Steel Corp.
/lan	should be nd Mental marked c	ToB	Joseph Bucharewicz Mary F	asca		
M. Aar,	2 sho and ls mu raum	1	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Run			
12:50 A. altimore, N	Pages 1 end nent of Health int: If item 27 iry or other t		1   Burial 2 □ Cremation 3 □ Removal from State   Cemetery, crematory or other place)	Date	20c. Location - City o	r Town, State
12: Baltir	permit. F Departme Importar any injur		Tarkwood centerery 02/10	F. Las	ssahn Funer	al Home, P.A.
•	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	or respiratory a	ırrest,	Approximate Interval Between Onset and Death
, 2006	ate be nysicië he bui	icai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.			
FEBRUARY 13 s, P.O. Box 68	death certifi e attending ed for use as	by Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (specify)		23d. Date of do Month	elivery Day Year
FEBI	w requires that been signed should be dei		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		tobacco use contribute Yes 2□No 3□F	to the cause of death?  Probably 4 Junknown
AREWICZ FE Vital Records,	a 2 C	Completed		24a. Was auto perfe 1 Yes	prior to ormed? prior to death?	autopsy findings available completion of cause of
REV Vita	Physician: this certifica ral director, I	Be	25. Was case referred to medical examiner?  Hospital:  Other:  Other:	th Check only	one	
CH.	ding After fune	tion: To	1   Yes   2   No		idence 6 Other (Sp how injury occurred	ecify)
FRANK BU Division	ei or Attend s after death I Director: A id in by the f	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		(Street and Number or F wn, State)	Ru <i>ral Route Number</i> ,
H	To the Hospitei or Attenwihin 24 hours after deali Within 24 hours after deali To the Funerel Director: completely filled in by the	edical (	29a. Certifier (Check only one)  1.2 Certifying Physician: To the best of my knowledge, doesnoocured at the time, date and learning of the basis of examination and/or investigation, in my opinion, death occur and manner stated.	and due to the	cause(s) and remier and did	es stated ue to the cause(s)
	To the within To the Comp	M	29b. Signature and title of certifier  Note: J. Man, MO  D32882		29d. Date signed (Mor	
	4		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  ROBERT MOSS, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM	M, MD 2		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 2006			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death . Decedent's Name (First, Middle, Last) Month Year 9:02 PM M Physician February 10, 2006 Frank Belcastro /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 6423 Hartwait Street Baltimore If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 0 6/29/1933 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 M 2 □ F 72 MD 212-30-5646 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or Iteme 23a or 28a-f ehow adical Examiner must be nutified at 1 Yes 2 □ No Directo MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21224 United States 6423 Hartwait Street Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Specify. White 1 ☐ Yes 2 ☑ Yo Specify: Baltimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced leted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then "natur 15. Decedent's Education (Specify only highest grade completed) Bethlehem Steel Compi Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be fits Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other treumatic event space. Be Rose Ferreri Frank Belcastro 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6423 Hartwait Street Baltimore, MD 21224 Mary Belcastro/Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Feb 14 1 ☐ Burial 2. Cremation 3 ☐ Removal from State Beltsville, Maryland 2006 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation and Funeral Alternatives 21. Signature of Funeral Service Licenses etteller MO1443 8717 Green Pastures Drive Baltimore, Maryland Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1. Exter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final e **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner prhosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit The law requires that the death certificate be executed Exami that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the l IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) detached the 9 Unknown 9 Unknown à 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed I al director, page 2 should be det 2 asci 1 ☐ Yes 2 No 3 Probably 4 Unknown alnu Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performec 1 ☐ Yes 2 ☐ No 1□ Yes 🗡 No Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 2 ☐ Accident 1 ☐ Yes 2 ☐ No death. investigation Director: the 6 Could not be determined 3 🗍 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire 0 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cal completely (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2006 30. Name and address of person who completed cause of death (ttem 23a) (Type, Print) to J Osler Drive, # 210 Duson, 10 MI Knodell Kebert Registrar's Signature °5 2006 State Registrar

	For Stata Registrar	State of	Maryland / De	epartment of Certificate of		Mental Hy	giene () (	)6	04250
Physician /Medical	* (FQ) LICA		4DFORD			2. Date of Do Month FEBRU		Year 2006	3. Time of Death 7:00 PM
Examiner	North	WEST H	DATIGO	- BA	n, or Location of De	RE	BA		ORE
Funeral Director	5. Social Security Number  217-38-512  Usual Residence of Decede	9 1 M 2 X F	7. Age (In yrs. last birtho	Months   Day		n (Month D	rth ay, Year) 19, 1943	9. Birthp	place (State or Foreigntry)
with the Maryland a or 28a-f show be rediffed at	10a. State 10b. Co	N/A	10c. City, Town of	IMORE				1	0d. Inside City Limits  Yes 2 □ No
b with the 23a or 2		TULTON	AVE	10f. Zip Cod	1217		10g. Citizen of	What Cour	•
hours after death variet, or Iteme 23	3 X Widowed 4 □ Divo	Married 1 Yes	2 <b>25.</b> No	13. Was Decedent of Yes, specify C	of Hispanic Origin? uban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Ra	ce - Americ ck, White,	an Indian,
ed within 72 hours at ygiene.  ygiene.  ygiene.  it, tre Meulce Exern  Completed by F	15. Dec (Specify only in Elementary/Secondary (0-	edent's Education highest grade completed)  12) College (1-	(C	ecedent's Usual Oct Bive kind of work do le. DO NOT use ret	ne during most of w ired)	· ·		unity	COLLEGE
d off	17. Father's Name (First, Mi		<i>A</i>	/10use/	18. Mother's N	ame (First, Middle		тө)	
should and Men marke umatic	19a. Informant's Name/Rela		NOEN 19b. N	lailing Address (Stre	EVEL eet and Number or	Rural Route Numb	NZCAP er, City or Town		
Pages 1 and 2 should be filled be filled be filled by the	20a. Method of Disposition	QUIRE JOAU tion 3 Removal from S	20b. Place of D cemetery,	45 BKE isposition (Name of crematory or other p HIU C	place)	Date	20c. Location	- City or To	m 2113. own, State
permit. Pages 1 a Department of He Important: If Item eny injury or othe once.	21. Signature of Juneral Se		- L	22. Name and Add	dress of Facility	EVERIN !	D. Crom	RETI	E 715
Physician /Medical Examiner	23a. Jant. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)	aDue to (o	or as a sinsequence of):	DIAL		ac or respiratory a	rrest,	ma.	Approximate Interval Between Onset and Death
cate be executed physician and the burial-transit dical Examiner		c	or as a consequence of):						
n certific anding puse as	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 215No 9 □ Unknown	1 ☐Live bir	ome of pregnancy th 2 ☐ Fetal death nt at time of death wn	3 □Ectopic pregnar 5 □ Other (specify)				ite of delive	ory Day Year
wrequires that the death been signed by the atte should be detached for leted by Physicia	Part II. Other significant cor	nditions contributing to dea	ath but not resulting in th	e underlying cause	given in Part I.				e cause of death?
ysician: The law re is certificate hes ber director, page 2 sho fo Be Complet						24a. Was auto perfo 1≱ Yes	ormed?	prior to con death?	osy findings available npletion of cause of 2 \square
Physician: The this certificate I ral director, pag.	examiner?		patient 2 ☐ ER/Outpa	tient 3 DOA	Note	eath <i>Check</i> only o		er (Specific	, l
To the Hospital or Attending Physician: The law requires twithin 24 hours efter death.  To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be a Medical Certification: To Be Completed by	27. Manner of Death  17 Natural 5 Pe 2 Accident in 3 Suicide 6 Co	28a. Date of (Month) (Month) (Month)	Injury 28b. Tim , <i>Day Year)</i> Inju	e of 28c. In	jury at /ork? ☐ Yes 2 ☐ No	28d. Describe	how injury occur	red	
Itei or Al urs efter or rei Direc led in by		etermined 286. Place of building	of Injury - At home, farm, g, etc. <i>(Specify)</i>			City or To			
To the Hospitel or within 24 hours effe to the Funeral Dir completely filled in I	29a. Certifier 1 Certifier (Check only one)	tifying Physicien: To the b lical Exeminer: On the bas and manne	sis of examination and/o	eath occurred at the r investigation, in my	time, date and place y opinion, death occ	ce, and due to the curred at the time,	cause(s) and ma date and place,	anner as sta and due to	ated. the cause(s)
To I To I com	<b>)</b>	10	- MS	7		2			Day, Year)
\( ) State	30. Name and address of per  NO NOTE A  31. Date filed (Month, Day, Y	EST HOSPI		pe, Print) M OLD (OUT	ITERA	TOBOK D RAND	ALLSTO	IUN	HD 21133
Registrar		5 2006		(ask)					

		•	1 - For State Registrar	State of N	Maryland		rtment of He		nd Mental H	lygiene Reg. Nõ.	Ullh	04251
#	/K	Ø .	Decedent's Name (First, Middle, La	st)					2. Date of	Death		3. Time of Death
H	Physici /Medic		Dane Brown I	30aas					FOOTU	ary 11		
	Examin		4a. Facility Name (If not institution, give		r)		4b. City, Town, or	Location o		-	County of De	ath
	**		Upper Chesapeak				Bel A		W.IV T		Harfor	
7	Funeral		5. Social Security Number 6. S	Sex 7.7 IS⊋M 2□F	Age (In yrs. Ias 80	t birthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. 8. Date of (Month, NOV •	Birth Day, Year) 100	9. 8i	nthplace (State or Foreign Country)
	Director		179-20-9267 Usual Residence of Decedent		80				1100.	, 192	.5 Pla	ryLand
	yland		10a. State 10b. County		10c. City, 7	Town or Lo	cation					10d. Inside City Limits
	a-f s	ctor	Maryland Harfo	rd.	Bel	Air						1 ☐ Yes 2 🖾 No
	or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What C	Country?
	ath w		206 E. Heather H	T-			21014				SA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Madical Examinat must be notilised at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 § If Yes, Give Year or Dates	s? ⊋No	1	Vas Decedent of His Yes, specify Cubar ☐ Yes 2 No	spanic Orig n, Mexican Specify:	jin? (Specify Yes or , Puerto Rican, etc.)	No-	14. Race - Am Black, Wh Specify:	
2-0	72 ho	Completed	15. Decedent's E	ducation		16a. Deced	lent's Usual Occupa kind of work done d	tion	of working	16b. Ki	nd of Busines	
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4o	r 5+)	life. L	OO NOT use retired)	oning most	or working			
N	filed wi Hygien other th	Con	12			Owne	r/ Operat				liance	Sales
	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Ire Mi	Be	17. Father's Name (First, Middle, Last						r's Name (First, Mide		Sumame)	
Ž	should ind Men ind marke imarke	ဥ	Roy Jirdon Boo			19h Mailin	a Address (Street a		a Bertie I ror Rural Route Nui		r Town State	Zin Codel
Ma	id 2 s Ith an 27 le i		Mary A. Boggs /	•			•		ad, Bel Ai			210 0000
ē,	Health tem 27 other tr		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of		Date		cation - City o	r Town, State
OE .	Pages nent of P ant: If its ary or of		1 🔀 urial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci		i e		emorial C	-	2-14-06	Bel	Air. M	aryland
Baltimore,	그 본관 중		21. Signature of Funeral Service Lice		DCI.	- T		<del></del>	Home, P.			7
m	Depa Impo any is		Steller alle	eli							, Mary	land 21009
	*		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caus one cause on each	ed the death. line.					200		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. (	alci	phy	laxis					Onset and Death  2 weeks.
	/Medical Examiner		resulting in death)	Due to (or a	as a consequer	nce of):						
187	i i	_	Sequentially list conditions,	b	as a consequer	nce of\:						
$\sqrt{7}$	ted nsit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due 10 (01 2	13 a consequen	100 01).						
Ç	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or a	as a consequer	nce of):						
8760,	hysicien the buri	dicai	(	d								
68	tificate ig phys as the											
Вох	death certifica attending ph d for use as t	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom	ne of pregnanc		Ectopic pregnancy			2	23d. Date of d	.,
Э. В	the att	Physician/Me	in the past 12 months?		at time of deat		Other (specify)			-	Month	Day Year
P.0	that the de ed by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions	contributing to don't	but not soculti	an in the	doch in a course awa	n in Dort I	220 D	id tobasso u	so contributo	to the cause of death?
of Vital Records,	Se C 99	1 by	End Stage			-	, -	ii iii Faiti.		☐ Yes 2[		Probably 4 Dinknown
Sor	w requir been si should	Completed by	J						24a. W	fac an	24h Wore	autopsy findings available
Rec	The lav	du							au	itopsy erformed?	prior to death?	completion of cause of
a		e Co	25. Was case referred to medical					OF Diago		s 2 No	1 🗌 Ye	s 2 No
5	Physician: this certific ral director,	To B	examiner?	Hospital: 1 Inpa	tient 2∏EF	VOutpatien	t 3 DOA Othe		of Death (Check on rsing Home 5□R		S □Other /Sn	ecifu)
o	g Phy er thi		27. Manner of Death	28a. Date of Ir (Month, L	njury 28	Bb. Time of	28c. Injury Work	at	28d. Descrit			00.147
jo	ath. ath. or: Aft	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	n	, oas,	iiijuty		es 2□n	10			
Division	I or Attending Phater death. Director: After th	Certification:	3 ☐ Suicide 6 ☐ Could not to determined	289. Place of	Injury - At home etc. (Specify)	e, farm, str	eet, factory, office			n (Street and Town, State		Rural Route Number,
	ital o rrs aft ral Di	Cel										
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical	29a. Certifier  (Check only one)  1 Certifying Pi 2 Medical Exa	nysician: To the be miner: On the basis and manner	of examination	edge, death n and/or inv	occurred at the time restigation, in my op	e, daté and inion, deat	d place, and due to t h occurred at the tim	he cause(s) ne, date and	and manner a place, and du	as stated. re to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier	1			29c. License		2 / 3			nth, Day, Year)
				1				> 55	012	168	orvar	7 12, 2000
	6		30. Name and address of person who			3a) (Type,	Print) Nortz	Av.	· Rol	Air	, md	y 12, 2006 . 21014
9	1 0 0		31. Date filed (Month, Day, Year)	70001	strar's Signatur		, , , , , ,			, , ,		
<b>V</b>	Sta Registi	100	FEB 1 5 2005	Alexan S	A. Julian	with o						

#035712

BOGGS, DANE BROWN

		1 - For State Registrar  1. Decedent's Name (First, Middle, Last		-	artment of H tificate of I			leg. No.	04252
Physi /Med		DERICK ANTHO		R			Month Februar	Day Yes	
Exam		4a. Facility Name (If not institution, give				Location of Death		4c. County of D	eath
Funera Directo		214-72-8273		In yrs. last birthday) 49 Yrs.	BALTIN  If Under 1 Year  Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day NOV . 18	(Year)	Birthplace (State or Foreign Country) MARYLAND
yland		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or Lo	cation				10d. Inside City Limits
e Mar	Director	MARYLAND N/A		BALT	IMORE				1∕2√Yes 2 No
with th	a	10e. Street and Number			10f. Zip Code	. 7	1	10g. Citizen of What U.S.A.	Country?
deeth ms 23	nerai	1615 N PAYSON S	12. Was Decedent Eve	er in U.S. 13.	212] Was Decedent of H	L / ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No-		merican Indian,
is 1 and 2 should be filed within 72 hours after death with the Maryland of Heelth and Mental Hygiane.  Item 27 is marked other then "naturel", or items 23s or 28s-f show other treumatic event, the Medical Evantant must be notified at	by Funeral	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		fYes, specify Cuba 1 □ Yes 2 <b>\Z</b> X¥io	in, Mexican, Puerto Specify:	Rican, etc.)	Specify: BI	/hite, etc.
IVIGITY INTO A 1 A 1 D-0000 d 2 should be filed within 72 hours all th and Mental Hygiane. i? is marked other then "naturel, or treumatic event, the Medical Evant	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ing	16b. Kind of Busine	ess/Industry
d withir	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	1	NT TRANSI			HEAL	TH CARE
at Hyg	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)	
y ica nould b i Ment narke natic	2		0			ROSE W			
Wand 2 st lith and 27 is n		19a. Informant's Name/Relationship (T) Rose Coursey/Siste	•					r, City or Town, Stat , Maryland	
Dallillore, Dermit. Pages 1 ar Dapartment of Hee mportent: if Item:	1	20a. Method of Disposition		20b. Place of Dispo cemetery, crer				20c. Location - City	
Pages ment of the		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☐ Donation 5 ☐ Other (Specify)	TOTTO TOTTO TOTTO	METRO CF		02-1	3-06	BALTIMOR	E, MARYLAND
Dallinore, Maper permit. Pages 1 and 2 Dapartment of Heelth a Importent: if Item 27 is any Injury or other tre		21. Signature of Funefal Service Licens	66	WI	LLIAM C 1		MUNITY I	FUNERAL H	OME P.A.
Pnysicia: /Medica Examine		22a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	e death. Do not ent  Consequence of):	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between Onset and Death
ertificate be executed ding physicien and se as the burial-transit	Medical Examiner	resulting in death) Last	d	consequence of):					
that the death certifed by the attending detached for use a	by Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at tir 9 ☐ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
w requires that is been signed I should be det			ntributing to death but	not resulting in the u	nderlying cause give	en in Part I.			e to the cause of death?  Probably 4 ①Unknown
INVISION OF VITAL RECOLDS, F.O. BOX I or Attending Physicien: The law requires that the death cert effect death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	Completed						24a. Was a autop: perfor 1 🗆 Yes	sy prior med? deat	e autopsy findings available to completion of cause of h? Yes 2 □ No
sicien s certif irecto	Be e	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outpatier	nt 3 DOA Oth	er: 4 D Nursian He	F		2
nding Phy ath. r: After this	ation: To		28a. Date of Injury (Month, Day )	28b. Time o	f 28c. Injun Wor			lence 6 Other (Sow injury occurred	Бреспу)
To the Hospital or Attending Physicien: The tawithin 24 hours effer death.  To the Funerel Director: After this certificate has completely tilled in by the funeral director, page 2	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	- At home, farm, sti (Specify)	reet, factory, office		28f. Location (S City or Tow		r Rural Route Number,
he Hospital or n 24 hours efte he Funerel Dire pletely fillad in i	Medical		sician: To the best of ner: On the basis of e. and manner state	xamination and/or in	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the d red at the time, o	cause(s) and manne date and place, and	r as stated. due to the cause(s)
To the within 2 To the complet	Ž	29b. Signature and title of certifier		F.	29c. Licens			29d. Date signed (M	
16			1000			9071		2-9-06	
7		30. Name and address of person who c	ompleted cause of dea	th (Item 23a) (Type,	Print)	7 470	RALTIA	nons	WS 4/20/
		31. Date filed (Month, Day, Year)	32. Registrar		2	, , ,	(3. 10 (l.		

2/9/06 AT HOME 108

Amend item#196, perFH, 0852, 2/15/06 IT Relack Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 00:24 AM Feb Bunn Essie Mae 10 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Hos pital Balti more Good Samaretan If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□M 2√2F Yrs. Director 81 215-22-6760 NC 06 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 ie marked other than "neture?" or items 23a or 28e-f show treumatic event, the Mudical Explainter must be notified at 1X Yes 2 □ No Baltimore MD NΑ Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 5113 Woolverton Ave Completed by Funeral 21215 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black X□ Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Domestic 5th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fund Mental I 2 Claude Barnes Bertha Barnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health Mary E. Jones-Step-Daughter 5113 Wolverton Ave 21215 Baltimore, Md other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) ŏ Department of Important: If any injury or once. 2/16/06 Baltimore Co, Md Woodlawn 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
March F/H West prette 4300 Wabash Ave, Baltimore, Md 21215 mes 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final colon Cancer Priysician Metastatic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy jo in the past 12 months 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Ö detached ٦ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 has certificate 2 No 1 ☐ Yes of Vital funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 2 <u>4</u> No 1 Yes this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; Division After Hospitel or Attending Natural 2 Accident 5 Pending death. 1 Yes 2 No investigation after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier Certifier (Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai venpletely To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Res 000 2.10.2006 Zimas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, BALTIMORE MD SAMARITAN KUMAR SUJEET 600D

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 5

32. Aegistrar's Signature

Charles of

			For State		epartment of Health and N Certificate of Death		ZUUb Hazbo
	Physici	an	1. Decedent's Name (First, Middle,		Continuate of Douth	Reg. N  2. Date of Death  Month  D	ay Year 3. Time of Death
N. Carlot	/Medic	al	4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Death	rebruary.	12, 2006 8, 45 m.
			Joseph Rice 5. Social Security Number 6	Shey Hospico	Baltimor	8 Date of Birth	9. Birthplace (State or Foreign
	Funeral Director		577-42-0171	Me off H	rs. Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Aug, 7, 19	29 Maryland
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location		10d. Inside City Limits
	the Mar 28a-f	Director	10e, Street and Number	A Ba	Itimore 101. Zip Code	100.0	1 V Yes 2 □ No
	23a or		6819 West	ridge Rd.	2/207	10g. 0	USA
"	fter dea r fteme frer m	Funerai	11. Marital Status  1 ⅓ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces? 1 DYes 2 DNo If Yes, Give	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - American Indian, Black, White, etc.
003	hours after death with the Maryland ture!', or fleme 23e or 28e-f show al Exercites must be multified at	þ	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	104	Specify: Black
21215-0036	within 72 ene. then "na! te Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life, DO NOT use retired)	king 166.	Kind of Business/Industry
	filed w Hygier other th	Be Cor	17. Father's Name (First, Middle, La	st)	Obation Utti(	ne (First, Middle, Maide	in Entercement
Maryland	should be nd Mental nmarked c	To B			unk. Blan	iche H	awkins
	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental bygiene in Health and Mental bygiene "naturel", or iteme 23a or 28a-f show other traumatic event, the Modical Exemples maint be notified at		19a. Informant's Name/Relationship  MS. Martha	(Type, Print) (Friend) 196.	Mailing Address (Street and Number or Ru	ral Route Number, City	or Town, State, Zip Code)
Baltimore,	Pages 1 and the total of the total of the total of the total of the try or other tr		20a. Method of Disposition 1,⊠ Burial 2 ☐ Cremation 3	Removal from State	v, crematory or other place)	Date 20c. I	Location - City or Town, State
altin	permit. Pages Department of Important: If it eny injury or once.		4 □Donation 5 □Other (Spe 21. Signature of Funeral Service Lie	I CI CCI V	150 n Forest 22	12006 UU	vings Mills, Ma.
8	8858	4.7	23a Parti Enter the disease or o	T C YSUSS that caused the death. Do n	2222 W. North Ave	uneral Ho	Md z 1216 Approximate
	Physician		Immediate Cause (Final disease or condition	ly one cause on each line.	ot enter the mode of dying, such as cardiac	or roopilatory arross,	Interval Between Opeet and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence o	rf):		97770
	P #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Que to (or as a consequence o	1)-		
٧	cate be executed bhysician and the burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a consequence o	of):		
9289	cate be physicia the bur	dicai		d		-	
Вох 6	death certific e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death	3 □Ectopic pregnancy		23d. Date of delivery
	that the dea led by the at detached fo	nysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of death 9□ Unknown	5 Other (specify)		Month Day Year
ds, P	98	þ	Part II. Other significent condition	s contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?
Vital Records,	aw as b 2 s	Completed				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
al B	ate pag	е Соп	25. Was case referred to medical			performed? 1 ☐ Yes 2 ☐ N	death?
		0 8	examiner? 1 □ Yes 2 7 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	patient 3 DOA Other: 4 Nursing H	th (Check only one) ome 5 Residence	6 Dother (Specify)
Division of	hy his il di	<b>-</b>		20a Date of Injury 20h T	ime of 28c. Injury at	28d. Describe how inj	un occurred
S	ding h. After fune		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, Day Year) In	ime of 28c. Injury at Work?  M 1 Yes 2 No	20d. Describe flow inj	ury occurred
≥	ding h. After fune		1 Natural 5 ☐ Pending	t be 200 Stage of Injury. At home far	M 1 ☐ Yes 2 ☐ No		and Number or Rural Route Number
Div	ding h. After fune	Certification:	1 Natural 5 Pending investiga 3 Surcide 4 Homicide 6 Could no determin	28e. Place of Injury - At home, far building, etc. (Specify)  Physician: To the best of my knowledge,	M 1 ☐ Yes 2 ☐ No m, street, factory, office  death occurred at the time, date and place,	28f. Location (Street a City or Town, Sta	and Number or Rural Route Number, te)
Div	Hospital or Attending 4 hours after death. Funerel Director: After ely filled in by the fune		1 Natural 5 Pending investiga 3 Surcide 4 Homicide 6 Could no determin	28e. Place of Injury - At home, far building, etc. (Specify)  Physician: To the best of my knowledge,	M 1 ☐ Yes 2 ☐ No m, street, factory, office	28f. Location (Street a City or Town, Sta and due to the cause rred at the time, date an	and Number or Rural Route Number, te)
Div	Hospital or Attending 24 hours after death. Funerel Director: After tely filled in by the fune	edical Certification:	1 Natural 2 Accident 3 Sutcide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - At home, far building, etc. (Specify)  Physician: To the best of my knowledge, taminer: On the basis of examination and and manner stated.	M 1 Yes 2 No m, street, factory, office death occurred at the time, date and place, for investigation, in my opinion, death occur  29c. License number	28f. Location (Street a City or Town, Sta and due to the cause rred at the time, date an	and Number or Rural Route Number, te) s) and manner as stated. nd place, and due to the cause(s)
Div	Hospital or Attending 4 hours after death. Funerel Director: After ely filled in by the fune	edical Certification:	1 Natural 2 Accident 3 Sutcide 4 Homicide  29a. Certifier (Check only one)  29b. Signature and title of certifier	28e. Place of Injury - At home, far building, etc. (Specify)  Physician: To the best of my knowledge, aminer: On the basis of examination and	M 1 Yes 2 No m, street, factory, office death occurred at the time, date and place, for investigation, in my opinion, death occur  29c. License number	28f. Location (Street a City or Town, Sta and due to the cause rred at the time, date an	and Number or Rural Route Number, te) s) and manner as stated. nd place, and due to the cause(s)

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ORIGINAL

			State of Maryland / Department of Health and Mental  1- State Registrer  Certificate of Death	Hygiene	11.256
				Reg. No.	3. Time of Death
6	Physici		COLDINATE RUTLER		1918 4
13	/Medic Examin			4c. County of Death	/ (
	÷	٠.	MERCY HOSPITAL BACTITIONE	NA	
	Funeral		5. Social Security Number 6. Sex 7. Agg (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date (Months Days Hours Min. (Months Days Min. (Mo	of Birth of Birth of Birthplac of Birthplac of Birthplac of Birthplac of Birthplac	ce (State or Foreign
~	Director		Usual Residence of Decedent	-25,1743 Mari	ylana
	yland		10a. State 10b. County 10c. City, Town or Location	10d	I. Inside City Limits
	a-f st	ctor	Maryland NIA Baltimore		1 XXYes 2 No
	or 28	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country	1?
	a 23a	rai	19 44 W. Battmore St. 2/223  11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes.)	USH	to dia a
	iter de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- c.) 14. Race - American Black, White, etc	
036	ai', or	þ	3 Widowed 4 Divorced Year or Dates:	Specify P	ck
Maryland 21215-0036	be filed within 72 hours after deeth with the Maryland Hygiene. de litylgiene. de other than "natural", or itema 23a or 28a-f show avant, I're Modical Exatricat must be notified at	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	16b. Kind of Business/Indus	stry
121	within	mp	Elementary/Secondary (0-12) College (1-4or 5+)	Oun H	0 100
d 2	should be filed within nd Mental Hygiene. marked other than imatic avant, I' e M	ပိ	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	liddle, Maiden Sumame)	mie
<u>a</u> n	lid be lental ked c	To Be	Henry Simmons Annie	Durham	
ary	should and Mer a marke	_	19a. Informant's Name Relationship (Type, Print) (Grandhaug Mer) 19b. Mailing Address (Street and Number or Rural Route N		ode)
	1 and 2 Health a am 27 is		Ms. Sherria Owens 14305 Kedhaven Ro	1. Balto. Md	1.21208
ore	Pages 1 nent of Hi int: if iten		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	20c. Location - City or Town	1, State
altimore,	~ ~ ~		4 Donation 5 Other (Specify) Garrison Forest 2/2//20	06 Owings M	ills, Md
Ba	permit. Departitions from the policy and injury inj		21. Signature of Funerat Service Licensee 22. Name and Address of Facility Lucy and Service Licensee 23. Name and Address of Facility Lucy and Lucy		,
100	Yarr	8	23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirat shock, or heart failure. List only one cause on each line.	alto, Md, 21214 tory arrest, A	Approximate nterval Between
	Physician		Immediate Cause (Finat disease or condition  a. SPIRATION PREUMONIA	O	Onset and Death
	/Medical		resulting in death)  Due to (or as a consequence of):	9	
	Examiner	L	Sequentially list conditions, b.		
Τ	nsit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury		
1	axecuin and al-trai	Exan	that initiated events c.  The sulting in death) Last Due to (or as a consequence of):		
8760	icate be executed physicien and s the burial-transit	dical	d		
89	ing ph	Medi	E IF FEMALE:		
Вох	leeth certific attending p	lan/l	23b. Was decedent pregnant in the past 12 months?	23d. Date of delivery Month Da	
o.	the de	Physician/Me	1  Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown		
σ.	that hed by deta	y Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	Did tobacco use contribute to the	cause of death?
rds	quires an sign uld be	ed b	Designaral VASalte disease	1 Yes 2 No 3 Probab	oly 45 Unknown
ဝင္ပ	taw re as bee 2 sho	piet	aute renal france 24a.	. Was an 24b. Were autops prior to comp	sy findings available pletion of cause of
œ =	The sete ha	Completed by	10	performed? death?	
Vita	ician: Sertific ector,	Be	25. Was case referred to medical examiner?	only one)	
ō	Phys r this ral dir	. To	Tightes 2 2000 235 patient 2 EH/Outpatient 3 DOA 4 Nursing Home 5	Residence 6 Other (Specify)	
on	th. ; Alte	tlon	27. Manner of Death 1  □ 1  □ 1  □ 1  □ 1  □ 1  □ 1  □ 1		
Division of Vital Records,	Attendi	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Loca building, etc. (Specify)	ition (Street and Number or Rural F or Town, State)	Route Number,
ā	ital or rrs afte ral Dia led in			or rown, state)	
	To the Hospital or Attending Physician: The law requires that the deeth certific within 24 hours after death. To the Funeral Diractor: After this certificete has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	edicai	29a. Certifier  (Check only one)  29 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the one)  20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the one)	time, date and place, and due to the	ed. he cause(s)
	o the o the omple	Med	one) and manner stated.  29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Da	ay, Year)
	r->   0	ļ	1 Jos Certy, NO 042134	FEB 9,2	006
	1/		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
	8		JOSEMA COSTA 301 ST PAUL PLACE BACTIO	MIRE, MD 212	202
	Sta Regist				

Tru Barton 06-01043 crn

l			Unpend item#23a,27	,28a-f,pen/E	(853,3/2/06	oeuble ink.	. Ensure A	Montal Hy	Are L	egible.	
			1 - For State Registrar	State of Mar		rtificate of			Reg. No.	006	04257
	72.		Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
	Physici /Medio		TRU SAVON RAY	BARTON				Month Februar	v 10.	Year 2006	11:32 A M
	Examin		4a. Facility Name (If not institution, give s	street and number)		4b. City, Town, o	r Location of Death	1	4c. C	ounty of Deal	
			Johns Hopkins Hosp			Balti				N/A	
7	Funeral		5. Social Security Number 6. Sex 182-76-8099	7. Age (/ M 2 F 1 (	n yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	v. Year)	l Co	hplace (State or Foreign ountry)
0	Director		Usual Residence of Decedent	10	, 113.			12/20	/199	5 PEN	NŚYLVANIA
	ylanc how		10a. State 10b. County	10	Oc. City, Town or Lo	cation					10d. Inside City Limits
	e Ma	ctor	PA YORK		WEST Y	ORK					1 Yes 2 No
	ith th	Funeral Director	10e. Street and Number			10f. Zip Code	_			of What Co	ountry?
	23a	rai	1226 W. KING ST		15.110 Jan	1740			US		
	tten de	ů,	11. Marital Status  1 ▼Never Married 2 Married	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☑ No		f Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14	Black, Whit	
920	hours after death with the Maryland urel', or tteme 23a or 28a-f ehow al Examinar must be notified at	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		s	Specify: BL	ACK
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hyglene. Item 27 Ie marked other then "naturel", or (teme 23a or 28a-f show other treumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	dent's Usual Occup	pation during most of wor	rkina		of Business/	
21	within lene. then	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	OO NOT use retired	d)	Kirig			
121	filed w Hygier other ti		3YRS  17. Father's Name (First, Middle, Last)		STU	DENT	10 84-45-4-81-	(Fina Middle		UDENT	•
and	iould be f Mental H narked of natic ever	Be	DAVID JOHN BARTO	ON TP			18. Mother's Nan	H M. R		ımame)	
Maryland	2 should be and Mental le marked of reumatic even	၉	19a. Informant's Name/Relationship (Type		19b. Mailir	ng Address (Street	and Number or Ru			Town State	Zin Code)
Ma	nd 2 :		DAVID JOHN BARTO			•	BOUNDA		. ,		
ē,	tem Item		20a. Method of Disposition	1	20b. Place of Dispo	sition (Name of natory or other place	ne)	Date	20c. Loca	ation - City or	Town, State
Ē	Page nent c int: If		1 We Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	SUSQUEHA			ENS 02/	17/0	6 YOR	K,PA.
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If Item 27 Is eny injury or other tre		21. Signature of Funeral Service License	60 M		. Name and Addre		10 6 00	NC O	0	
_	90 F P 9		Ville Car			ENRY W 6924 YO	RK RD M	S <sub>N</sub> & SO	, MD.	2111	1.
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused the e cause on each line.	e death. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between On set and Death
	Priysician		Immediate Cause (Final disease or condition resulting in death)	_Smoke inhal	lation						Onset and Death
1	/Medical Examiner			Due to (or as a c	onsequence of):						
		er	Sequentially list conditions, if any, leading to immediate	Due to (or as a c	onsequence of):						
	d d ansit	Examin	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
o,	eath certificate be executed attending physicien and for use as the burial-transit		resulting in death) Last	Due to (or as a c	onsequence of):		· · · · · · · · · · · · · · · · · · ·				
3760,	ate be nysici he bu	Ical	d								
89 x	e as t	Physician/Medi	IF FEMALE:								
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of p 1 ☐ Live birth 2	Fetal death 3	Ectopic pregnancy	,		23	d. Date of del Month	ivery Day Year
o.	that the de led by the a detached f	yslc	1 Yes 2 No	4☐ Pregnant at tim 9☐ Unknown	e of death 5	Other (specify)					,
Δ.	The law requires that the death certificate be executed its hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit		Part II. Other significant conditions con	tributing to death but n	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
rds	quires tha n signed uld be det	d by						10	Yes 2□	No 3∏Pr	obably 4 Mnknown
of Vital Records,	aw requir s been si 2 should t	Completed						24a. Was			itopsy findings available
R	The law sete hes l pege 2 s	E o							med?	prior to death?	completion of cause of
ita		Bec	25. Was case referred to medical examiner?				26. Place of Dea		Table 1 1	<u></u>	
× ×	Physician: this certifical	2	1 XYes 2 No		2 ER/Outpatien		4   Nursing H	ome 5 Resi	dence 6 [	☐Other (Spe	cify)
	ling P	inol	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Ye		Wor		28d. Describe	now injury o	occurred	
Division	uttendi death. ctor: A y the fu	licat	2 Accident investigation 3 ☐ Suicide 6 ☐ Could not be	2/9/2006 28e. Place of Injury	12:55 A	1	Yes 2 No	victim of			real Poute Number
Οį	after after I Dire	Certification:	4 Homicide determined	building, etc. (s	Specify)	set, factory, office		York, Per	vn, State)	226 W. K	ural Route Number, ing St.
	To the Hospital or Attending Physician: The Funders after death as a feet death To the Funerel Director. After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phys	ician: To the best of n	ny knowledge, death	occurred at the tir	me, date and place	, and due to the	cause(s) ar	nd manner as	stated.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Exeminone)	ner: On the basis of ex and manner stated	amination and/or inv I.	estigation, in my o	pinion, death occu	rred at the time,	date and p	ace, and due	to the cause(s)
	with To 1	≥	29b. Signature and title of certifier	1 /1		29c. Licens	e number		29d. Date	signed (Monti	h, Day, Year)
			M	11. //			C.M.E.		Febru	ıary 11	2006
			30. Name and address of person who con	mpleted cause of deat			+ Dol+4	more M-		A 2120	)1
	Sta	te	31. Date filed (Month, Day, Year)	23 Registrar's		аш эсгее	t, Balti	nore, Ma	путаг	14 414(	)T

DHMH 17 Rev 1/2001

Registrar

		1 - For Si	ate of Ma	-	epartmen Certificat			and M		jiene	006	04258
		Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death
Physic /Medi		Lor	etta Ma	rie Band	dy				Februar			10:30 A M
Exami		4a. Facility Name (If not institution, give stree	t and number)				Location o	of Death		4c. Co	unty of Death	
		6809 Roberts Avenue			Ι	unda	llk					ltimore
Funeral		5. Social Security Number 6. Sex	1277 -	(In yrs. last birth	Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)	9. Birth	hplace (State or Foreign untry)
Director		212-12-0215	89	9 Y	rs.				Oct. 31	1,1916		ryland
b s		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	or Location							10d. Inside City Limits
Aaryl	ō	Maryland Baltimo						Dur	nda1k			1 ☐ Yes 2 🛣 No
28a-	Director	10e. Street and Number			10f. Zip	Code			1	IOn Citizer	of What Co	untov?
with a or	2						217	222			ted St	
heath	Funeral	6809 Roberts Ave	Nue Vas Decedent E	ver in U.S.	13. Was Dece	ent of His			cify Yes or No-		Race - Ame	
ther of	Fun	1 Never Married 2 Married 1	med Forces?	0				, Puerto F	cify Yes or No- Rican, etc.)		Black, White	e, etc.
urs a	þ	3 ☑ Widowed 4 □ Divorced	f Yes, Give Year or Dates:		1 🗆 Yes	2 <b>⊠</b> No	Specify:			Sp	ecify:	White
72 ho	Completed	15. Decedent's Education (Specify only highest grade con		16a. I	Decedent's Usua Give kind of wo	ol Occupa	tion	t of workin	10	16b. Kind	of Business/I	Industry
thin thin	ple		College (1-4or 5+	·) '	Give kind of wo life. DO NOT u	se retired)	i i i i i i i i i i i i i i i i i i i	OI WOIKII	<i>'</i> 9			
L POSK	ပ်	4 Years			Homen						Own H	ome
d be fill hootal H	Be	17. Father's Name (First, Middle, Last)					18. Mothe	r's Name	(First, Middle,	Maiden Su	mame)	
aty iditio Z   Z   3-0030 should be filed within 72 hours after death with the Maryland not Mental Hyglene. In marked other than "natural", or Items 23a or 28a-1 ahow unatic avant. Its Medical Examination that be notified at	2	Lawrence Goeb							y Burns			
	П	19a. Informant's Name/Relationship (Type, I			Mailing Address					. ,		
and 2 and 2 mealth ar m 27 la		Mrs. Joan Pretty	(Daughte		809 Rob		Aver		_			
DEMILITION OF THE PAGES 1 and 2 Depertment of Health a Important: If Itam 27 is any injury or other tra		20a. Method of Disposition  2 ☑XBurial 2 ☑ Cremation 3 ☑ Remo	val from State	cemetery	Disposition (Nar. , crematory or o	ne or ther place	9)	D	ate	20c. Locat	ion - City or	Town, State
Dallillo Dermit. Pages Depertment of mportant: If I nny injury or once.		4 □ Donation 5 □ Other (Specify)		Garris					2/13/200	)6 Ov	vings 1	Mills, MD
Description of the post of the		21. Signature of Funeral Source Licensee	NV	2000	22 Name and Duda - F	d Address	s of Facility Fune:	y ral H	ome of	Dunda	alk, I	nc.
707 a d		OUPMUL	11/	WEX	7922	Wise	Ave.	Du	ndalk.	Marvl		21222
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one car	ons that caused t tuse on each line	the death. Do no e.	ente the mod	e of dying	, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition	Myocard	lial Inf	arction							Oriset and Death
/Medical Examiner		resulting in death)	Due to (or as a	consequence o	f):							
Examiner		Sequentially list conditions, b	Cardio	vascula	r Diseas	se						
sit ad	luer	cause. Enter Underlying	Due to (or as a	consequence of	η.							
end Fran	Examine	Cause (Disease or injury that initiated events resulting in death) Last	Due to for as a	consequence o	11.						_	
cate be executed physicien end it the burial-transit	cal E		200 10 (01 23 2	oonsaquence o	')•							
OI VILLAI RECORDS, F.O. BOX 00 (00), Physician: The law requires thet the death certificate be executed this certificete has been signed by the attending physicien end ral director, page 2 should be detached for use as the burial-transit		d			_							
wrequires thet the death certifical been signed by the attending phathough be detached for use as it	Physician/Med	IF FEMALE: 23c I	f yes, outcome o	f pregnancy						224	Data of data	
Bath attention for u	ian	in the past 12 months?	1 Live birth 2	Fetal death	3□Ectopic pr 5□ Other (sp					230	Date of deli Month	Day Year
et and bed	ysic		Unknown	inte of death	3 Cities (sp	ocny)						
thet I		Part II. Other significant conditions contribu	uting to death but	t not resulting in	the underlying c	ause give	n in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
uires uires d be	d by	Hypertension							1 🗆 Y	es 2 🗆 N	lo 3□Pro	obably 4 XUnknown
requires been signs should be	ete								24a. Was a		Ab Moss au	teasy findings available
has pe 2	Completed								autops perform	sy	prior to death?	topsy findings available completion of cause of
Ital I	_								1 ☐ Yes	21XNo		2 No
VII siclar certii recto	o Be	25. Was case referred to medical examiner?	ital:			Othe	-		(Check only on			
Tarthis and disperse	-	M 162 5 140	1 U Inpatien			/A	4 🗆 Nu	_	ne 5 🖾 Reside			cify)
SION tending leath. tor: After the fune	tlon	, data and	8a. Date of Injury (Month, Day	Year) In	jury M	8c. Injury Work 1 □ Y	? ′es 2 ⊡t			over in query or	30403	
deal deal ctor	fica	3 Suicide 6 Could not be	8e. Place of Injur	ry - At home, far	m, street, factors				8f. Location (Si	treet and N	lumber or Ru	ral Route Number,
DIVISION Hospital or Attending 24 hours efter death. Funeral Director: After	Certification:	4  Homicide	building, etc.	(Specify)	, , , , , , , , , , , , , , , , , , , ,	,			City or Town			
spita nours neral		29a. Certifier 1 Certifying Physicia	n: To the best of	f my knowledge,	death occurred	at the tim	e, date an	d place, a	and due to the c	ause(s) an	d manner as	stated.
Ho 124 P	Medical	(Check only 2 Medical Examiner:	On the basis of and manner stat	examination and	or investigation	in my op	inion, deat	th occurre	ed at the time, d	late and pla	ace, and due	to the cause(s)
To the Hospital or Attending Physician: The lav within 24 hours effer death.  To the Funeral Director: Affer this certificate has completely filled in by the funeral director, page 2.	M	29b. Signature and title of certifier			290	. License	number		2	9d. Date s	igned (Monti	n. Dey. Year)
		) (		w o		D00	4715	57			2.	-13-06
		30. Name and address of person who comple	eted cause of de		Type, Print)							
		Yoon Kim, M.D. 911				uite	14 E	3alti	more, M	iaryla	and 2	1237
St	ate	31. Date filed (Month, Day, Year)	32. Registra	r's Signature								
Regist	trar	FEB 1 5 2006	Medina	J. J.	parti							

		1 - For State Registrar	State of M	/larylar		artmen rtificat			ınd M	lental Hygi	eņe g. No.	) 6	04259
Physic /Medi		Decedent's Name (First, Middle, L JENNIE	MABEL		COX					2. Date of Death	XY <sup>Day</sup> 14,	<b>Ž</b> 006	3. Time of Death 2:30P M
Exami		4a. Facility Name (If not institution, g STELLA MARIS HO	OSPICE CEN	TER			TI	Location o	M		4c. Count	y of Death BALTI	MORE
Funeral Director		5. Social Security Number 6.  215-03-8628  Usual Residence of Decedent	Sex 7. A 1 □ M 2 1 F	Age (In yrs. 87	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day, 8-25-19	<sup>Year)</sup> 118	9. Birthpl Count MA	ace (State or Foreign try) RYLAND
Maryland a-f ehow	tor	10a. Slate 10b. County	LTIMORE	10c. Ci	ty, Town or Lo	ocation		I	ROSEI	DALE		10	0d. Inside City Limits 1 ☐ Yes 2 No
with the	Director	10e. Street and Number 7403 SOUTH ROA	D.			10f. Zip				10	g. Citizen of		•
d 2 should be filed within 72 hours after deeth with the Maryland th and Mental Hygiene. It and Mental Hygiene 7 is marked other then "neture!; or iteme 23s or 28s-f show treumatic event, it a Madical Examiner must be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 NWidowed 4 Divorced	12. Was Deceder Armed Forces	s? ₹No	1	Was Deced If Yes, spec 1 ☐ Yes	lent of Hi offy Cuba	spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	ocify Yes or No- Rican, etc.)		U.S.Z ce - America ck, White, e	an Indian,
within 72 h iene. 'then "netu 'the Medica	Completed by	15. Decedent's l (Specify only highest g Elementary/Secondary (0-12)	Education rade completed) College (1-4o	r 5+)	16a. Dece (Give life.	kind of wor DO NOT us	k done d e retired	ation turing most MAKEF		ng 1	6b. Kind of E		ustry HOME
should be filed ind Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Las CHARLES	st)	W	ILSON		IIOTI		r's Name	(First, Middle, N			
permit. Pages 1 end 2 sho Depertment of Health and Important: if tem 27 le ma any injury or other treum ang.e.		19a. Informant's Name/Relationship ROBERT RETTMAN S  20a. Method of Disposition 1 Burial 2 □ Cremation 3 4 □ Donation 5 □ Other (Spec	ON □Removal from Stat	9	7403 Place of Disponentery, cres ARKWOOD	SOUT	H RO ne of ther place TERY d Addres	DAD  9) 7 s of Facility	2–18	3-2006 ACH/ROSEI	MD 0c. Location PARKV	21237 - City or Too ILLE, UNERAI	wn, State
death certificate be executed EXA am edianding physicien and entending physicien and of for use as the buriel-transit	dical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate course. The fundering Cause (Disease or injury that initiated events resulting in death) Last	a. DEMENT  Due to (or a  b. Due to (or a  c. Due to (or a  d.	is a conseque	quence of):								
	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcom 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 Feta	ıl death 3 ☐	Ectopic pro Other <i>(sp</i> e						ate of deliver	y Day Year
w requires that the been signed by the should be deteche	b	Part II. Other significant conditions	contributing to death	but not res	sulting in the u	nderlying ca	use give	n in Part I.					e cause of death?
The law ete hes b page 2 si	Completed					-			_	24a. Was an autopsy perform 1 Yes 2	ed?	death?	sy findings available opletion of cause of 2 No
Physicien: rthis certific ral director.	To Be	25. Was case referred to medical examiner?  1 Yes 2 XNo	Hospital: 1   Inpai	tient 2 🗆	ER/Outpatien	ıt 3□ DO	Othe			Check only one		ner (Snech)	HOSPICE
ding h. After tune	Certification; 7	27. Manner of Death  1 ANatural 5 Pending 2 Acciden investigation	28a. Date of In (Month, D		28b. Time of Injury		Bc. Injury Work	at ? /es 2 🗆 N	2	28d. Describe how			HOST TOE
is E in a	Certifi	3 Suicide 6 Could not determined	d 28e. Place of I	etc. (Specif	<sup>(y)</sup>					28f. Location (Str. City or Town,	State)		
To the Hospital within 24 hours e To the Funerel I completely filled	Medical	one)	Physician: To the bes aminer: On the basis and manners	or examina	owledge, death	vestigation,	in my op	inion, deat	i place, a h occurre	ed at the time, da	te and place,	and due to	the cause(s)
0		29b. Signature and title of certifier				I	License	number 372	5	29	d. Date signe	id (Month, E 14/06	Pay. Year)
Oj		30. Name and address of person who  DR. TARIO MAHMOO	D 2300 D	UT.ANE	Y VALL	EY RD	. Т	IMONI	UM,	MD 21093			
Sta Registi	_	31. Date filed (Month, Day, Year) FFR 1 5 2006		trars Signa	ature	9							

DHMH 17 Rev 1/2001

2:30 p.m.

FEBRUARY 14, 2006

JENNIE COX

ADH WILLIAM COLES Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland 7 Department of Health and Mental Hygiene 06 - 1126Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Coles 13**, FEBRUARY** 2006  $A^{M}$ 0925 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE 4b. City, Town, or Location of Death **Examiner** PIKESVILLE 4410 OLD COURT ROAD | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 07 2 - 2 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 220.40.8468 1**℃**M 2□ F 63 Yrs. MD 1947 Director Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Mudical Examiner roughts notified at MD Ba Himore Completed by Funeral Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Old Cour Road 21133 USA 4410 23a or stama 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after obsardment of Heelth and Mental Hygiene. Important: if tem 27 is marked other than "natural", or tist important: if tem 27 is marked other than "natural", or tist important of the marked other traumatic event, the Marked Exaculted Object. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black 3 ☐ Widowed 4 ☐ Divorced Specify: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maintenance Worker Janitonal 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be J.C. Goodmar Rosa Mae Colo ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carter Keith 2256 Linden Avenue Baltimore MD 21217 Cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State 02.18.06 Baltimore, MD Greenmount 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Compassion fully eyal Services
119-121 s. Stricker street Baltimore MD 21223 Eun 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Hypertessive afteruscientic cardiovascular Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine ettending physicien end for use as the burial-fransit To the Hospitel or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 □ No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an page 2 s autopsy .performed? certificete 1 Yes 2 🗆 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 NOther (Specify) SCENE ၉ 1X Yes 2 □ No 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident Injury 5 Pending death. м 1 □ Yes 2 □ No nours efter death nerei Director: / / filled in by the fi investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours e To the Funerei C completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State

Registrar

ABILLCAN 31. Date filed (Month, Day, Year)

FEB

29b. Signature and title of certifier

(Check only

32. Registrat's Signature

of person who completed cause of death (Item 23a) (Type, Print)

renn

29c. License number

Street ,

OCME

29d. Date signed (Month, Day, Year) FEBRUARY 14, 2006

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		1 - For State Registrar	,	ertificate of Death	Reg.	2006 01.261
Physic /Med		1. Decedent's Name (First, Middle, Last) Louise R. Co	ates		2. Date of Death Month	Day Year 3. Time of Death 12 2006 4.40 PM
Exam		4a. Facility Name (If not institution, give s 3711 Reisterstov		4b. City, Town, or Location of Death  Bultimore		4c. County of Death
Funera Directo		5. Social Security Number 6. Sex 214 26 6056		Months Days Hours Min	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country) MD
Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  A  A	10c. City, Town or Balt	Location		10d. Inside City Limits 1 □XYes 2 □ No
th with the 23s or 28a ISI be noti	Funeral Director	10e. Street and Number 3711 Reisters	town Road	10f. Zip Code 21215	10g.	. Citizen of What Country?
ING 21215-UU36 be filed within 72 hours after death with the Maryland tal Hygiene. d other than "netural", or items 23s or 28e-1 show event, the Medical Examinat must be routlised at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	3. Was Decedent of Hispanic Origin? (Sr If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 d within 72 hours af giene. er than "natural, or the Medical Exem	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+) (Gi	cedent's Usual Occupation ive kind of work done during most of work b. DO NOT use retired)	king	b. Kind of Business/Industry  Healthcare
Iryland 212 should be filed within and Mental Hygiene. marked other than matic event, the M	3e Co	17. Father's Name (First, Middle, Last)			e (First, Middle, Ma	iden Sumame)
	To Be	TESSIE Mc Crat		illing Address (Street and Number or Ru	Shield	
M2 d d 2 is the art trau		Albert W. Coate	28/Husband 371	1 Reisterstown R	oad Bal	timore MD 21215
Baltimore, Dermit. Pages 1 at Department of Hea Important: If them any injury or othe		20a. Method of Disposition  1   Surial 2 □ Cremation 3 □ R  '4 □ Donation 5 □ Other (Specify)	lemoval from State	sposition (Name of rematory or other place)  TOYEST 02:2		c. Location - City or Town, State
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature of Funeral Service License	~ Mo1363	22. Name and Address of Facility Vaush C. Greene 49.05 York Rd. Bo	Funeral	Services ND 21212
		23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final	cations that caused the death. Do not	enter the mode of dying, such as cardiac	or respiratory arrest	
Pnysicial /Medica	l'	disease or condition resulting in death)	Due to (or as a consequence of):	CITC DIENST	Cuncer	
Examine		if any, leading to immediate	Due to (or as a consequence of):			
recuted and I-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):			1
68 / 60, Ificate be executed physician and ts the burial-transit	Aedicai E	L.	1.			
I Records, P.O. Box 68760,  The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of delivery Month Day Year
rds, P., quires that the n signed by uld be detact	b	Part II. Other significant conditions cor	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
Hecords, The law requires to also be seen signed page 2 should be considered.	Completed				24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death?
VIta sician: certifica rector,	o Be C	25. Was case referred to medical examiner?	Hospital:	Other	th (Check only one)	- A Flot (0 - 1)
VISION OF VITAL Re Attending Physician: The I r death. ector: After this certificate ha ety the funeral director, page	l len	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time Injury	e of 28c. Injury at	28d. Describe how	ee 6 □Other (Specify) injury occurred
	Certification;	2 Accident Investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
Di To the Hospital or within 24 hours afte To the Funeral Dir completely filted in	Medicai C	29a. Certifier (Check only one) Certifying Physical Examination	sician: To the best of my knowledge, doner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place r investigation, in my opinion, death occu	, and due to the caus rred at the time, date	se(s) and manner as stated. a and place, and due to the cause(s)
To the within To the	Me	29b. Signature and title of certifier	$\wedge$	29c. License number		Date signed (Month, Day, Year)
1/		30. Name and address of person who co	ompleted cause of death (Item 23a) (Ty			211412006 mr 21202
\	tate	31. Date filed (Morffit, Day, Year)	32. Aegistrar's Signature	301 Strail PI	12017	and alda
Regi	itate strar	FED 1 5 20	RE Decree & A	sere!		

			For State		State of Maryla	-			ental Hygie	enen n 6	14262
			Registrar  1. Decedent's Name (Firs	t Middle Last		Cei	rtificate of	Death	Reg 2. Date of Death	No.	3. Time of Death
	Physici		Toseph	i, Middle, Last)	albert				. Month	Day Year	3:00 AM
	/Medic Examir		4a. Facility Name (If not in	stitution, give s	street and number)		4b. City, Town, o	r Location of Death	j-eb	8 2006 4c. County of Death	3:00/1/1
	LAdiiii	ICI	Cromus	ell	Nursimil	Home	Ba	Limone	2		
	Funeral		5. Social Security Number		7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	1	8. Date of Birth Month, Day, Y	9. Birth	place (State or Foreign
	Director		218-07-17 Usual Residence of Dece	φ.	(M 2 F 8	P Yrs.			3-15-		hington, DC
	land ow			County	10c. 0	City, Town or Lo	ocation				10d. Inside City Limits
	Mary	tor	MD		'	Bal.	timor	<b>7</b> 0 )			1 XYes 2 No
	h the	Director	10e. Street and Number	,	. 7	^	10f. Zip Code		10g	g. Citizen of What Cou	ntry?
	within 72 hours efter deeth with the Maryland ene. than "natural", or items 23e or 28e-f show the Medical Exam er must be rectified at	aiD	626 lu	abrio	dye Roa	d	212	12		USA	
	r dee	by Funeral	11. Marital Status		12 Was Decedent Ever in		Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	s efte	y F.	1 Never Married 2		Armed Forces?  1 ★ Yes 2 □ No If Yes, Give		1 □ Yes 🄏 No	Specify:		Specify: PIC	CK
21215-0036	hour	ed E		ecedent's Edu	Year or Dates:	16a, Dece	dent's Usual Occup	ation	16	6b. Kind of Business/in	dustry
215	nin 72 an 'nin	piet	(Specify on Elementary Sector dary	y highest grade	Completed) College (1-4or 5+)	(Gina	kind of work done DO NOT use ret <u>ired</u>	during mast of workir	ng .	^	·
212	d with giane er the	Completed	24h	(0-12)	College (1-401 5+)		Shef		1	DOD Se	rvices
	be filed ital Hygi of other	Be	17. Father's Name (First,	Middle, Last)	11 01			18. Mother's Name	(First, Middle, Ma	niden Sumame)	- 1
yla	2 should be filed withir and Mental Hygisne. le marked other than aumatic event, the Ma	10	WILLIAM	10	1 bert			George	- ANN	a Col E	xx+
Maryland			19a. Informant's Name/P	elationship (Ty	pe, Print)	19b. Mailir	ng Address (Street	and Number of Rura	Route Number, C	City or Town, State, Zip	Code)
	1 and 2 Health am 27		20a, Method of Disposition	COID	206 - WY	Place of Dispo	sition (Name of	riage	ate De	oc. Location - City or To	Win State
nor	Pages nent of int: If it		Burial 2 Cre			cemetery, crer	natory or other plac	(38)	ا برام		
Baltimore,			21. Signature of Funeral			411501	Warme and addre	serof Facility	414 00 (	WingsMi	45/19
Ba	permit. Departr Importe any inje		1 Gen	11.	Suo	Ľ	angra	C Circle		eral Ser	212
	N 5 70		23a. Part1. Enter the dis	ease, or compli	cations that caused the de le cause on each line.	ath. Do not ent	er the mode of a in	ig, such as cardiac or	respiratory arres		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	re. List only of	la Causa di Bacil III la	111 1	cyhish	inia			Onset and Death
1	/Medical		resulting in death)	•	Due to (or as a conse	equence of):	giri	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
-	Examiner		Sequentially list condition	e l	. =						
	D ==	iner	if any, leading to immediate.  Cause (Disease or injury	ate _	Due to (or as a conse	equence of):					
	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	٥	Due to (or as a cons	aguana of):					
60,	be ex ician burial	ai E			Due to (or as a consi	equence or,					
68760,	tificate ng phys as the	edicai									
Box (	leath certifi attending I for use as	/W	IF FEMALE: 23b. Was decedent preg	nant 2	3c. If yes, outcome of preg	nancy				23d. Date of delive	erv
ă	death a atter	cial	in the past 12 month		1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of		Ectopic pregnancy Other (specify)	<u> </u>		Month	Day Year
P.0	that the de ed by the detached	Physician/M	9 Unknown		9□ Unknown						
	igned be det	by P	Part II. Other significant	conditions cor	tributing to death but not re	esulting in the u	nderlying cause giv	en in Part I.		cco use contribute to t	
brd	w require been si should l	ted							1 Tes	2 Mario 3 □ Prot	oably 4 Unknown
Records,	law r as be	Completed							24a. Was an autopsy	prior to co	psy findings available impletion of cause of
H		Con							performe 1 ☐ Yes 2 ☐	d? death? 1 ☐ Yes	2 No
of Vital	Physician: r this certific ral director,	Be	25. Was case referred to examiner?	·	lospital:		Oth	26. Place of Death	-		
of	this ald	7	1 Yes 2 No		' 1 ∐ Inpatient 2	ER/Outpatien	it 3 DOA	4 Uniursing Hor	ne 5 Residence 8d. Describe how	ce 6 Other (Specif	(y)
o	Jing Aftel fune	tion	1 Natural 5	Pending investigation	28a. Date of Injury (Month, Day Year)	Injury	Wor	yat k? Yes 2 □ No	od. Describe now	injury occurred	
Division	Attendiir death.	fica		Could not be determined	28e. Place of Injury - At	home, farm, str			8f. Location (Stree	et and Number or Rura	il Route Number,
ō	s after	Certification:	4  Homicide	dotoiiiiiod	building, etc. (Spe	cify)			City or Town, S	State)	
	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the fune	Medical (	29a. Certifier 1 (Check only 2 1	Certifying Phys Medicel Exemi	sicien: To the best of my k ner: On the basis of exami and manner stated.	nowledge, death nation and/or in	n occurred at the tirvestigation, in my o	ne, date and place, a pinion, death occurre	nd due to the caused at the time, date	se(s) and manner as s a and place, and due to	tated. the cause(s)
	To the Within To the	Me	29b. Signature and title of	certifier	17		29c. Licens	-		I. Date signed (Month,	
	$\mathcal{A}_{i}$		<b>)</b> (9.	inglin	CAJO, MO		Doa	59855	F	eb. 9, x	006
	10		30. Name and address of	person who co	mpleted cause of death (It	em 23a) (Type,	Print) Rave	en Blvo	l. Bal	eb 9, x	02/234
	Sta	ite	31. Date filed (Month, Da	y, Year)	32. Rightrar's Sig	nature	aster)		1		- /
	Regist	ar	FF	B 1 5 20	005	15 19					
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DHMH 17 Rev 1/2001

KHURAM CHAUDRHRY 06-01088 RJ

		State Registrar	Otato of it	faryland / De <i>C</i>	ertificate					04263
Physicia /Medic	an al	Decedent's Name (First, Middle, La	Khuran	n Chaudhi				2. Date of Death Month February	Day Yea 7 11, 200	6 10:40 p
Examin		4a. Facility Name (If not institution, given University - Shoots	k Trauma		Ba1	timor		0.5(5:1)	4c. County of De	none
Funeral Director		5. Social Security Number 6. S  220-90-6610  Usual Residence of Decedent	Sex 1 M 2 □ F	Age (In yrs. last birthd	Months I		urs Min.	8. Date of Birth (Month, Day, )  June 9, 15		Birthplace (State or Ford Country)  Pakistan
ous allel beath with the maryand rel', or Items 23a or 28a-1 show Exercities trust be notified at	ctor	Maryland Anne 10e. Street and Number	e Arundel	10c. City, Town o		Glen E	Burnie			10d. Inside City Lin
ms 23a or	Ta	841 Bentwillow Dr.	12. Was Deceden	it Ever in U.S.	10f. Zip C	nt of Hispan	21061 c Origin? (Spe	cify Yes or No-		J.S.A. merican Indian,
rel', or ite	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates	No	If Yes, specify	Cuban, Me	xican, Puèrto I ecify:	Rican, etc.)	Specify:	hite, etc. Pakistani
within 72 hours 6ne. than "naturel", re Medical Exe	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-40)	(G	ecedent's Usual ( live kind of work e. DO NOT use	done durina		16	6b. Kind of Busine: Reta	ss/Industry il / Jewelry
and Mental Hygiene. is marked other than aumatic event, II.o Mi	To Be Co	12 17. Father's Name <i>(First, Middl</i> e, <i>Lasi</i> Yagut	Chaudry					(First, Middle, Ma	aiden Sumame)	
Solution and an arrangement of the manual rate of the state of the marked other than "nature or other traumatic event, the Medical		19a. Informant's Name/Relationship   Mrs. Mussarat Chauce 20a. Method of Disposition	(Type, Print)		841 Bentv	illow Dr	. Glen Bur	nie, Marylan	City or Town, State  1d 21061  Oc. Location - City	
4 4 6 7		1 Signature of Funeral Service Lice	fy)		Shepherd (	er place)	02/1	8/2006		city, Maryland
Departm Importa eny Inju		23a. Part1. Errer the disease, or con shock, or heart failure. List only	C Bugil	MDIZG3	Sla	ck Fune	ral Home.	P.A. Tike Ellicott (	Çity, MD 210	Approximate Interval Between
physician be executed by society and by sicien and by sicien and by sicien and six and	ai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. — Due to (or a	is a consequence of):		wou	nd o	f hea	Ųd.	
e attending phys	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		ie of pregnancy 2   Fetal death at time of death	3 □Ectopic preg 5 □ Other (spec				23d. Date of o	delivery Day Year
ned by detac	by Ph	Part II. Other significant conditions		hut not considire in th						
an sign	ed t		contributing to death	but not resulting in th	e underlying cau	se given in	Part I.	23e. Did toba 1 ☐ Yes	V	
ne law ete has b page 2 st	Completed t		contributing to death	but not resulting in th	e underlying cau	se given in :	Part I.	1  Yes  24a. Was an autopsy performs	24b. Were	Probably 4 Unkr autopsy findings avai o completion of cause ?
ne la ete has page 2	Be Completed	25. Was case referred to medical examiner?  TY□ Yes 2□ No	Hospital: 1 XInpai		e underlying cau	26.	Place of Death	1 Yes  24a. Was an autopsy performe 1 Yes 2 Check only one	2 No 3 D  24b. Were prior 1 death 1 12 Y	Probably 4 Unkr autopsy findings avai o completion of cause es 2 No
ning Frigsteien: Ine law n. After this certificete has b funeral director, page 2 st	To Be Completed	25. Was case referred to medical examiner?	Hospital: 1 \(\times\) Inpai  28a. Date of In  (Month, D  28e. Place of In building.	tient 2 ER/Outpa jury lay Year) 28b. Tim Inju -0 5 Francisco	e of 28c y	26. Other: 4. Injury at Work? 1 ☐ Yes	Place of Death  Nursing Hon  2 2 10/No	1   Yes  24a. Was an autopsy performed to the second one of the se	2 No 3   24b. Were prior 1 death   1 (1) Y	Probably 4 Unkn autopsy findings avai o completion of cause es 2 No pecify)  himself Rural Route Number,
ning Frigsteien: Ine law n. After this certificete has b funeral director, page 2 st	edical Certification: To Be Completed	25. Was case referred to medical examiner?  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigatic 3 Suicide 6 Could not 4 Homicide determined	Hospital: 1 X Inpai  28a. Date of In (Month, D)  Pond Z-I  28e. Place of In blace of In blace of In hysician: To the bes	tient 2 □ EP/Outpa jury 28b. Tim Injury - At home, farm elc. (Specify)	atient 3 DOA e of 28c ry 1:3 M , stre 1, actory, o	26. Other: 4. Injury at Work? 1 Yes office	Place of Death  Nursing Hon  2 2	24a. Was an autopsy performe 12 Yes 20 Check only one 8d. Describe how 41 by 24 City or Town, Then Bur	2 No 3 2  24b. Were prior 1  ead? death death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Probably 4 Unkn autopsy findings avail to completion of cause es 2 No pecify)  Array Route Number, folsom was as stated
is all or Autoning Prysicien. The law is affect death. el Director: Affect his certificete has b ed in by the funeral director, page 2 st	To Be Completed	25. Was case referred to medical examiner?  Y Yes 2 No  27. Manner of Death  1 Natural 5 Pending investigation  3 Suicide 6 Could not to determine determined  29a. Certifier (Check only)  2 Medical Examiner	Hospital: 1 \( \) Inpai  28a. Date of In (Month, D)  28e. Place of In building, At An  hysician: To the besininer: On the basis and manner s	tient 2 ER/Outpa jury lay Year) 28b. Tim Injury - At home, farm etc. (Specify) and OV 5 D st of my knowledge, d of examination and/o stated.	e of 286 yy 286 yy 286 yy 286 yy 296 yy 296 yy 296 yy 296 y	Other: 4 Injury at Work? 1 yes office was Letter time, dan my opinior occurs num OCME	Place of Death  Nursing Hon  2 2 (VNo  te and place, a, death occurre	24a. Was an autopsy performed to the caution (Stree City or Town, and due to the cautid at the time, dat	2 No 3 2  24b. Were prior 1  ead? death death 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	es 2 No  pecify)  him self  Rural Route Number,  folsum www.  as stated. lue to the cause(s)

		1 - For State Registrar	State of Marylan		artment of tificate of		nd Mental Hy	rgiene 0 0 6	04264
Physic /Medi		1. Decedent's Name (First, Middle, Last) George H. Clark, J					2. Date of De Month FCb T	uary 12,2	oce 1410m
Examir	ner	4a. Facility Name (If not institution, give s			•	or Location of [	Death	4c. County of De	
		Upper Chesapeake M  5. Social Security Number 6. Sex			Be I	Air	Hre a Day (B)	Harfo	
Funeral Director		217-22-1098 <sup>1</sup>	7. Age (In yrs.	Yrs.	Months Day		Min (Month, Da	ay, Year)	rthplace (State or Foreign country) ryland
and	1	Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
Mary f sho	jo	Md. Harford	ŧ		Ahinada	n n			1 ☐ Yes 2 ☐ No
288	Director	10e. Street and Number			Abingdo			10g. Citizen of What C	
h with		311A Tall Pines Co	urt		2	21009		U.S.A.	
inc, wall year of E.E. 12-0000 s. 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23s or 28s-1 show other treumatic event, the Madical Examinational banoillist at	y Funerai	1 ☐ Never Married 2 X Married	2. Was Decedent Ever in U. Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:		Was Decedent of Yes, specify Cu		n? (Specify Yes or No Puerto Rican, etc.)	14. Race - Arr Black, Wh	ite, etc.
hours LEAT	d by	3 Widowed 4 Divorced							
n 72 n 72	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	lent's Usual Occ kind of work don DO NOT use retil	e during most o	f working	16b. Kind of Busines	s/Industry
with the same	шс	Elementary/Secondary (0-12)	College (1-4or 5+)		ronics	,,,,,		governm	ent
Hyg other		17. Father's Name (First, Middle, Last)		CICCO	LOHILOD	18. Mother's	Name (First, Middle		icire .
ild be kental	To Be	George H. Clark, S	r.			Edna	I. Bromwe	11	
Viol y idea ( L. C. L. C. L. C. L. C. L. C. L. C. L. C. L. C. L. C. L. C. L. C. L. C. C. L. C. C. C. C. C. C. C. C. C. C. C. C. C.	J-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailin	g Address (Stre	et and Number	or Rural Route Numb	per, City or Town, State,	Zip Code)
alth a		Catherine T. Clark	:/wife	3114	A Tall F	Pines Co	urt, Abin	gdon, MD 21	009
permit. Pages 1 and 2 Department of Health a Important: if Item 27 is any injury or other tre once.	1 8	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re		lace of Dispo	sition (Name of natory or other p	lace)	Date	20c. Location - City of	r Town, State
Pages Iment of tant: If it		4 □Donation 5 □ Other (Specify)	Ga	rdens o	of Faith	Cem 2	/16/2006	Baltimore	, Md.
Dennit. Departiment import	1	21. Signature of Funeral Service License		22	Name and Add	ress of Facility	al Home o	f Bel Air,	Inc.
7 702 9		·un	//		510 W. M	[acPhail	Road, Be	1 Air, Md.	21014
Physician		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	ations that caused the death cause on each line. Ischemi			ying, such as ca	rdiac or respiratory a	arrest,	Approximate Interval Between Onset and Death  2 & 10015
Medical Examiner Dubsician and The burial-transit	Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq  Due to (or as a conseq  Due to (or as a conseq	uence of):	D174	fizile	Colitiz		5 days
To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medicai	JF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	ic. If yes, outcome of pregna 1  Live birth 2  Feta 4  Pregnant at time of d	fdeath 3□	Ectopic pregnar			23d. Date of d Month	alivery Day Year
that the ed by detach		Part II. Other significant conditions conf	ributing to death but not res	ultina in the u	nderivina cause o	given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
en sign	ted by		osis				10	Yes 2□No 3□F	Probably 4 Donknown
al neca n: The law r licate has be r, page 2 sh	Completed		e some				1 ☐ Yes	proprior to death?  2 □ No 1 □ Ye	
elcia certi	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital:	ER/Outpatien			Death Check only		
Phy Prints	$\Gamma \vdash \Gamma$	27. Manner of Death	28a. Date of Injury	28b. Time of		4 □ Nursi		idence 6 Other (Sp	ecify)
tree function	tior	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		lork? □Yes 2□No		, ,	
tal or Atter s after dea sl Director ed in by the	Certification:	3 Surcide 6 Could not be determined	28e. Pface of Injury - At he building, etc. (Specification)	ome, farm, str	eet, factory, offic	68		(Street and Number or I wn, State)	Rural Route Number.
e Hospi 24 hours e Funer letely fill	edical	29a. Certifier 1 Certifying Phys (Check only 2 Medical Examin	cian: To the best of my known: On the basis of examina and manner stated.	wiedge, death tion and/or in	occurred at the vestigation, in my	time, date and p y opinion, death	place, and due to the occurred at the time,	cause(s) and manner a date and place, and du	as stated. se to the cause(s)
To the withing To the comp	×	29b. Signature and title of certifier	21			nse number		29d. Date signed (Moi	
			J- 11		I	3501	2	Februar	7 12,2006
12		30. Name and address of person who obj	npleted cause of death (Item	23a) (Type,	Print)			, md. =	
St Regist	ate rar	31. Date filed (Month, Day, Year) FFR 1 5 20	32. Pegistrar's Signa		sels.				

				1 - For Stata Registrar	State o	f Marylan			of Health a	nd Ment		ene 1. No.	04265
		Physici	an	1. Decedent's Name (First, Middle, Last							ate of Death	Day Yea	3. Time of Death
	F.	/Medic		Carl Damon Claus  4a. Facility Name (If not institution, give		nber)		4b. City, T	own, or Location of	f Death	bruar.	4c. County of De	ath
	1	Examin	er	Upper Chesapeake		,			Bel Air			Harf	ord
	April 2	Funeral		5. Social Security Number 6. Se	x	7. Age (In yrs.	last birthday)	If Under Months	Year II Under 2 Days Hours	24 Hrs. 8. D Min. (A	ate of Birth Nonth, Day, Y	(ear) 9. B	irthplace (State or Foreign Country)
		Director		406-22-2528	QM 2□F	79	Yrs.	IN GITTING	Days		v. 26,		Kentucky
		land		Usual Residence of Decedent  10a. State  10b. County		10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits
		Mary -1-hc	tor	Maryland Harf	ord		R	el Ai	r				1 ☐ Yes 2 🙀 No
		h the	Director	10e. Street and Number	.oru			10f. Zip			10g	. Citizen of What (	Country?
		23a c		710 Kings Path					21014			U.	S. A.
		wrs after death with the Marylan al, or Items 23a or 28a-f ehow Exemiter mast be notified at	Funeral	11. Marital Status	Armed Fo		.S. 13. \	Was Decede f Yes, spec	ent of Hispanic Orig fy Cuban, Mexican,	in? (Specify ) Puerto Ricar	es or No- , etc.)	14. Race - An Black, Wi	nerican Indian, nite, etc.
	36	rs afte	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes If Yes, Giv Year or D	/8		1 ☐ Yes 2	∑ No Specify:			Specify:	White
	215-0036	within 72 hours after death with the Maryland ene. than "natural", or Items 23a or 28a-f ehow tha Madical Exemiter must be natilled a	ted	15. Decedent's Edu	cation		16a. Deced	lent's Usua	Occupation		16	Sb. Kind of Busines	
0	215	hin 7.	Completed	(Specify only highest grad Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT us	k done during most e retired)	of working		Water T	reatment
3	N	ed withir ygiene. ner than it, the M	Con		3 yea	rs		Engi				Comp	any
5	land	be filed that Hygie od other	Be	17. Father's Name (First, Middle, Last)							_	uiden Sumame)	
	laryla	s 1 and 2 should be filed within I Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Ma	T <sub>0</sub>	Emil Carl Clauss  19a. Informant's Name/Relationship (7)			19b. Mailir	ng Address	(Street and Number	ce Dur		City or Town. State	Zin Code)
	Ma	and 2 s ealth an n 27 is in		Ann Clauss (Wife)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			_	Path, Be				
2	ē,	jes 1 and 2 of Health if item 27 if		20a. Method of Disposition		1 ,	Place of Dispo	sition (Nam	e of	Date		c. Location - City	
	altimore,	permit. Pages Department of I Important: If its eny injury or o		1 XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)		State	-	-	ardens 0	2/13/20	006 Ве	el Air, M	laryland
-	ati	rmit. spartn ports y inju		21. Signature of Funeral Service Licens	ee								ome of 21014
4	<u> </u>	89889		MU	10	1.							el Air, Md.
	1	Physician /Medical Examiner	)r	23a. Part1. Enter the disease, or compishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	a	aused the deal	in fr	er ine mode	Clisee	cardiac or res	piratory arres		Approximate Interval Between Onset and Death
37	68760,	icate be executed physicien and s the burial-transit	edicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of):						
3499	.O. Box (	at the death certifical by the attending phy lached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ ∀es 2 □ No 9 □ Unknown	1 Live b	come of pregna pirth 2 Feta ant at time of down	I death 3	Ectopic pre Other (spe				23d. Date of o Month	lelivery Day Year
40	rds, P	The law requires that the site has been signed by the bage 2 should be detache	δ	Part II. Other significant conditions co	1	eath but not res	sulting in the u	nderlying ca	use given in Part I.				to the cause of death?  Probably 4 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
and	I Record		Completed								24a. Was an autopsy performe	prior t	autopsy findings available o comptetion of cause of ? es 2 No
0	Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:					of Death  Ch			
888	of	ing Ph Mer th uneral	tlon: To	1 Yes No 27. Manner of Death 1 Naturat 5 Pending investigation		npatient 2 of Injury th, Day Year)	ER/Outpatier 28b. Time of Injury		A 4 Nui Bc. tnjury at Work? 1 Yes 2	28d. I		ce 6 □Other (S <sub>i</sub> r inju <b>ry</b> occurred	pecify)
Jan	Division	7 5 5	Certification:	3 Suicide 6 Could not be determined		of Injury - At hing, etc. (Specil		eet, factory,	office		ocation (Stre City or Town,		Rural Route Number,
0		To the Hospital or within 24 hours after To the Funeral Directon pletely filled in b	edicai	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	iner: On the b	asis of my kno asis of examina ner stated.	wiedga, daall ation and/or in	vestigation,	in my opinion, deat	place, and d h occurred at	the time, date	e and place, and d	ue to the cause(s)
		With To t	Σ	29b. Signature and title of certifier	_			1	License number		1.5	d. Date signed (Mo	
		•		Daved 3	Du				3229	2	P	chrunca	5.2006
		8.		30. Name and address of person who co					R-1-	rm			0
	10	Sta	ite	31. Date liled (Month, Day, Year)	32 <b>4</b> R	tegistrar's Signa	ature /	na. 1	*37/10	1- m	17		
		Registi		FEB 1 5 20	06	Signer A	The first						

			1 - State of Maryland / D	-	rtment of tificate o		Mental Hy	giene Reg. Ño.	006	04266
	Physici /Medic		Decedent's Name (First, Middle, Last)     EARL SINCLAIR CUMMINGS				2. Date of D Month 2	eath Day 3	Year 2006	3. Time of Death  11:45p M
	Examin		4a. Facility Name (If not institution, give street and number) 3509 Madonna Lane		Bowie	n, or Location of Deat		Pr	County of Deat	ge
	Funeral Director		5. Social Security Number 026-16-2744 6. Sex 1 M 2 F 83 Y  Usual Residence of Decedent	Yrs.	Months Day		(Month, D	rth ay, Year) 27,19		hplace (State or Foreign untry) sachusetts
	Maryland I ehow	tor	10a. State 10b. County 10c. City, Town Maryland Prince George Bowie	n or Loca	ation					10d. Inside City Limits 1 X Yes 2 □ No
	th with the 23a or 28a at the not	Funeral Director	10e. Street and Number 3509 Madonna Lane		10f. Zip Code 20715	9		-	en of What Co	* .
5-0036	be filed within 72 hours after death with the Maryland had lygiene. Id other then "natural", or items 23s or 28s-f show event. If a Madical Examination must be notified at	þ	11. Maritaf Status  1 □ Never Married 2 □ Married  3 □ Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Married Forces?  1 □ Never Married 2 □ Married  1 □ Married Forces?  1 □ Never Married 2 □ Married  1 □ Married Forces?  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Marr		/as Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puer No Specify:	Specify Yes or N to Rican, etc.)		4. Race - Ame Black, White Specify: V	
21215-U	filed within 72 he Hygiene. Ither then "natur int, tre Wedicel	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) Coflege (1-4or 5+)	(Give ki life. DO	ent's Usual Occ and of work don ONOT use ret	ne during most of wo ired)	rking	16b. Kir	nt of Business/	Industry
Maryland 2121	d a b	To Be C	17. Father's Name (First, Middle, Last) Earl Farrington Cummings			18. Mother's Nar Carrie Cec		, Maiden	-	
	is 1 and 2 should of Heelth and Men tem 27 is marke other traumatic			09 Ma	adonna La	ene Bowie Ma		0715	Town, State, Z	
altimore,	permit. Pages Department of I Important: if its any injury or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State	<i>y, crema</i> al Cr	atory or other p ematory	place)	/2006	Falls	Church,	
Ba	Dep Impo		23a. Part1. Enter the disease, or complications that caused the death. Do not	760	01 Sandy	Spring Road	Laurel M	arylan		Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of	4		rive els n				Interval Between Onset and Death O MONTING
8760, 12	The law requires that the death certificate be executed to the has been signed by the attending physician and age 2 should be detached for use as the burial-transit of	dicai Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of d.	of):	Piab	els n	pelli:	hus.		Zyeois
P.O. Box 6	the death certific y the attending p ched for use as I	Physician/Me	IF FEMALE. 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		Ectopic pregnal Other (specify)			2	3d. Date of defi Month	very Day Year
	w requires that the de been signed by the a should be detached f	þ	Part ff. Other significant conditions pontributing to death but not resulting in	the und	derlying cause	given in Part I.		tobacco us		the cause of death?
al Reco		Completed					1 Yes	ormed?	prior to death?	topsy findings available completion of cause of
Division of Vital Records,	Attending Physician: The lardeath. sctor: After this certificate haby the funeral director, page?	tion: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  1 Inpatient 2 ER/Outp  27. Manner of Death 1 Natural 5 Pending (Month, Day Year)  28a. Date of Injury (Month, Day Year)  1 Accident investigation		28c. fn V	26. Pface of Deadliness  4 Nursing Factors  Nury at Vork?  Yes 2 No		idence 6		cify)
Divisi	irsc irsc irsc	Certification:	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	rm, stree			28f. Location City or To	(Street and wn, State)	Number or Ru	ral Route Number,
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical	29a Certifier (Check only one)  1 Certifying Physician: To the basis of my knowledge 2 Medical Examiner: On the basis of examination and and manner stated.	death d d/or inve	estigation, in m	y opinion, death occu	s, and due to the urred at the time	, date and	place, and due	to the cause(s)
)	4	-	29b. Signature and title of certifier Cerrifier		$\mathcal{D}_{i}$	4810	1		signed (Monti	ı, ∪ay, rear}
	J.,		30. Name and address of person who completed cause of death (Item 23a) (T Donna Chambers 2002 Medical Park Way Suite  31. Date filed (Month, Day, Year) 32 Registrar's Signature	350	Annapoli	s, Maryland	21401			
*	Sta Registr		FFB 1 5 2006		S. O					

Amend item#205,5, perfit, 352,72/24/06 Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Moses William Douglas 4:07PM 2006 Febuary 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 2□ F Months Yrs. 84 Director 215-16-3220 06/26/1921 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itsms 23a or 28a-f show the Medical Examinar must be notified at 1 X Yes 2 □ No Maryland Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1727 Chilton Street U.S.A. 21218 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No 1942 If Yes, Give Year or Dates: 1945 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify **Black** ģ 3 ☐ Widowed 4 ☐ Divorced 1945 Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and 2 should be filed within a slith and Mental Hygiene.
27 Is marked other then "r traumatic event, the Med Elementary/Secondary (0-12) College (1-4or 5+) 6 Pipe Linesman Gas & Electric 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Deportment of Health and Mental Important: If I ism 27 Is marked any lightry or other traumatic evance. Edmond Douglas Mary Goings 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1727 Chilton St., Baltimore, Maryland 21218 Clara T. Douglas / Wife 20c. Location - City or Town, State Crownsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of Date Crownsville Vetthe Canaletery 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Forest Ceme 102/17/2006 Dwings Mills, Maryland 21. Signature of Funeral Sarvice 22. Name and Address of Facility The Derrick C. Jones F/H, P.A. License 4611 Park Hgts. Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Intracionial Immediate Cause (Final disease or condition resulting in death) 3 days Hemon hope **Physician** /Medical Due to (or as a consequence ol): **Examiner** Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the deeth certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Tes 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ို 1 Inpatient 2 ER/Outpatient 3 DOA s efter death.
Il Director: After this
of in by the funeral d 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours e To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) AT 2438946 February 10, 2006

DHMH 17 Rev 1/2001

State Registrar MD, UNION MEMORIAL HOSPITAL

, BALTIMORE, MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

HINA GHAFOOR

31. Date liled (Month, Day, Year)

			1 - State Registrar	•	(	Certifica	te of Dea	ath	F	Reg. No.		U 1 6m U U
	Dhysisi	22	1. Decedent's Name (First, Middle, Las	st)					2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		Stephen	М.	Delv	vecchic	Sr Sr		Februar	y 11,	2006	10:48 AM
	Examin	er	4a. Facility Name (If not institution, give	·			, Town, or Loca	tion of Death			ounty of Death	
			7023 Fifth Avenue				oundalk				Baltimor	
	Funeral Director		5. Social Security Number 6. S 214–12–4303	ex 7. Age (/r □XM 2□F	yrs. last birth	Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day August	Year)	9. Birthp Cour	lace (State or Foreign
Ų			Usual Residence of Decedent						August .	3, 191	Mary	rland
Van	MO TH		10a. State 10b. County		c. City, Town						1	0d. Inside City Limits
M	all a	io	MD Baltimo	ore		Dunc	alk					1 ☐ Yes 2 📉 No
ţ	or 28	ire	10e. Street and Number			10f. Z	ip Code			10g. Citize	n of What Cour	ntry?
÷.	23a	Funeral Director	7023 Fifth Avenue	9			21222				USA	
a a	T T T T T T T T T T T T T T T T T T T	une	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Dece If Yes, spi	edent of Hispani ecify Cuban, Me	ic Origin? (Spe ixican, Puerto	ecify Yes or No- Rican, etc.)	14.	. Race - Americ Black, White,	
	o.	by F	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 🗆 Yes	2X No Spe	ecify:		S	pecify: Whi	te
should be filed within 29 hours after death with the Maruland	a E		15. Decedent's Ed	l	16a D	ecedent's Us	ual Decupation			16h Kind	of Business/Inc	duetor
<b>9</b>	Wed	Completed	(Specify only highest gra	de completed)	(	Give kind of wife. DO NOT	ork done during	most of works	ng	TOD: TUNG	0, 500,000	dustry
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3	al Hy	Bec	17. Father's Name (First, Middle, Last)				18. A	Nother's Name	(First, Middle,	Maiden Su	umame)	
ק ק	Ment	2	Michael Della Vec	chia				Felici	ana Carl	bonar	a	
<b>10</b>	and ie m		19a. Informant's Name/Relationship (7	Type, Print)	19b. A	Mailing Addres	s (Street and N	umber or Aura	I Route Numbe	r, City or T	own, State, Zip	Code)
<b>1</b>	lealth m 27 her tr		Marie Delvecchio	wife				7	dalk,Md			
5 8	if its		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Domeual from State	Ob. Place of D	crematory or	other place)	Febru		20c. Loca	ition - City or To	own, State
9	rtmen		4 Donation 5 Other (Specify	"	ardens of			<u> </u>				Maryland
	Department of Health and Mental Hygiene important; or Iteme 23a or 28a-1 ehow any injury or other traumatic event, the Medical Exprirer must be a callified at once.		21. Signeture of Funefal Service Licen	Lann	eller	Conne 7110	Tly Fun Sollers	eral Heral Heral	ome Of I Road, I	Dunda Dunda	lk,P.A. lk,MD.	21222
			23a. Part1. Enter the disease, or compshock, or heart failure. List only	plications that caused the	death. Do no							Approximate
P	hysician		Immediate Cause (Final disease or condition		•							Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a co	nsequence of	):	accord	<u> </u>				
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0	==	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co								
ent e	and I-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a co	neaguana of							
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icate of	phys s the	Medical		d								
Cert.	nding use e		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pr	egnancy					230	d. Date of delive	Nrv
de de	e atte	Physician	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ 4 □ Pregnant at time	Fetal death	3 ⊟Ectopic p 5 ⊟ Other (s					Month	Day Year
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es the	ep ec	by F	Part II. Other significant conditions of	ontributing to death but no	t resulting in t	he underlying	cause given in F	Part I.	23e. Did to	bacco use	contribute to th	ne cause of death?
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3 2	as be	pie	Hypo Typoulsi						24a. Was a autops	an a	24b. Were auto	psy findings available impletion of cause of
Ę	page	Completed							perfor	med?	death?	2 X No
iclan	sertifi ector	å	25. Was case referred to medical examiner?	Hospital:				Place of Death	(Check only or	ne)		
2 5	this aldir	-T	1 Yes 2 No 27. Manner of Death	1 Inpatient	2 ER/Outp				me 5 Resid			y)
j 6	After fune	ţ	1 Natural 5 Pending 2 Accident investigation	(Month, Day Ye	ar) Inje	ury M	28c. Injury at Work? 1 ☐ Yes		28d. Describe h	ow injury c	occurred	
Atte	ctor y the	fica	3 Suicide 6 Could not be	28e. Place of Injury -	At home, farm				28f. Location (S	treet and f	Number or Rura	l Route Number,
2 2	s efte	Certification;	4  Homicide	building, etc. (S	pecify)				City or Tow	n, State)		
Joseph	within 24 hours efter death. To the Funarei Director: After this certificete has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use es the burial-transit		Check only 2 Medical Exam	ysician: To the best of miner: On the basis of exa	y knowledge, o mination and/o	death occurred	at the time, da	te and place, a	and due to the c	ause(s) an	nd manner as st	lated.
e d	hin 2 the t	Medical	uner)	and manner stated.								
Ę	₹ <b>2</b> §		29b. Signature and title of certifier	4		29	c. License num				signed (Month,	
	. 1		30 Name and address of	completed assessed death	(1) 22 : =		raix	6 X		2-	15-06	
	10		30. Name and address of person who a	completed cause of death	(item 23a) (T	ype, Print)	Ct	Rad	to, pr	.0 =	7/1110	/
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature	M -	>/	1000	w, ju	W C	100)	
	Registr		EED 1 5 2006	March A	Car.	and the same						

**Examiner**  4a. Facility Name (If not institution, give street and number)  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  **Durch of the control of Death  **Durch of the con	Pag. No.  Death Day, Year 4c. County of Death Day, Year 4c. County of Death A  Birth Day, Year 1 9. Birthplace (State or Foreign County) 10d. Inside City Limits 12 Yes 2 \[ \text{No.}
Physician Medical Examiner  1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  1. Decedent's Name (First, Middle, Last)  2. Date of Month FUNDLE  4a. Facility Name (If not institution, give street and number),  4b. City, Town, or Location of Death FUNDLE  4b. City, Town, or Location of Death Fundle  4c. City, Town, or Location of Death Fundle  4d. C	Death Day, Year Ac. County of Death Ac. County of Death Day, Year Ac. County of Death
Physician /Medical Examiner  4a. Facility Name (If not institution, give street and number)  The physician of Death  Adv. City, Town, or Location of Death  Adv. City, Town, or Location of Death  Button of Death  Button of Death  Button of Death  Button of Death  Button of Death  Funeral  Director  5. Sex 150 a first support  1 Months Days Hours Min.  Wonth Director  Usual Basidence of Decedent	Birth Day, Year 9. Birthplace (State or Foreign Country) 10d. fnside City Limits
Funeral Director  - Funeral Director  S. Septis Septification of Decedent  - Funeral Director  - Funeral Director  S. Septis Septification of Decedent  - Funeral Director  - Funeral Dire	Birth Day Year)  9. Birthplace (State or Foreign Country)  1921  10d. fnside City Limits  1929  2 No
Funeral Director  5. Says Septiment See 6. Sex 1 Age (In yrs. last birthday) 1 M 2 XF 7. Age (In yrs. last birthday) 1 Months Days Hours Min. Months Days Hours Min.	Day, Year)  18, 1921  Country)  10d. fnside City Limits  18 Yes 2 \( \text{No} \)
Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10d. Zip Code  10f. Zip Code  10f. Zip Code  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	10d. fnside City Limits 197Yes 2 □ No
Total Status  Md. N/A Baltinus  106. Street and Number  107. Zip Code  2 (2 17)  11. Marital Status  12. Was Decedent Ever in U.S.  Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	1 Yes 2 □ No
10e. Street and Number 16 38 N. Monroe St. 2 (2 17) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	
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3 Widowed 4 Divorced Year or Dates:  1 Yes 25 No Specify:  1 Yes 25 No Specify:  1 Yes 25 No Specify:  1 Give kind of work done during most of working	Specify: Slack
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The state of the s	Coleman
	mber, City or Town, State, Zip Code)
20a. Method of Disposition 20Demoval from State 128 N. m My St. Date of Disposition (Name of emetery, crematory or other place)	20c. Location - City or Town, State
4 Donation / 5 Other (Specify) MT Zum Cem 2-18-06	Lausdowne, mg.
) D E C C X O I X D P ( 147 L I V	n Pass three Beets, md. 21229
23a. Pair. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock or year failure. List only one cause on each line.	y arrest, Approximate Interval Between
Physician Immediate Couse (Final disease of prodition resultingly death)  A Massician (Modified Pastro)  a Massician (Pastro-Intestinal B)	eeding Onset and Death
Examiner End Strang Remail 105 10 CP	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
6876C	
Por the property of the proper	23d. Date of defivery
Section of the part of the p	Month Day Year
	oid tobacco use contribute to the cause of death?  ☐ Yes 2☐ No 3☐ Probably 4☑ Unknown
24a. Variety of the property o	Vas an utopsy 24b. Were autopsy findings available prior to completion of cause of
The state of Death (Check or D	erformed? death?
25. Was case referred to medical examiner:    Solution   Check or   Check or	
1 Pending  1 Pending	Residence 6 Other (Specify)
27. Maning of Death  1 Natural 5 Pending (Month, Day Year)  280. Time of 280. Injury at Work?  28d. Descr  (Month, Day Year)  1 Yes 2 No	
27. Manna of Death  1 Natural  2 Accident  3 Suicide  4 Homicide  28a. Date of Injury  (Month, Day Year)  28b. Time of Injury  4 Injury at Work?  1 Yes 2 No  28d. Descr  28d.	on (Street and Number or Rural Route Number, Town, State)
29a. Certifier (Check only 2)   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number	the cause(s) and manner as stated. me, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number	ne, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)  2/12/06
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier  29c. License number  29c. License number	me, date and place, and due to the cause(s)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physici /Medic		1. Decedent's Name (First, Middle, Last) Raman1a1	Desai						2. Date of Dea Month FEBRUAR	Day	Year 006	3. Time of Death 4:23P. M
	Examin		4a. Facility Name (If not institution, give		-)		4b. City, Town, o		of Death		4c. County	of Death	
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	Funeral Director			M 2□ F	61	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day Jan. 21	Year)	9. Birthp Cour	place (State or Foreign ntry) India
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Maryl	tor	MD Montgon	nerv			Burtonsvi	م11					1 ☐ Yes 🏋 No
	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of V		ntry?
	death with the Maryland ms 23a or 28a-f ehow		4105 Swiss Stone		t Ever in II	5 42.1	No. Donate A. (I	2086				ndia	
	s 1 and 2 should be filed within 72 hours after death with the Marylan ff Health and Mental Hygiene. If Health and Mental Hygiene "naturel", or Items 23a or 28a-f show other traumatic event, the Modical Examinational be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces 1 Yes 2 X If Yes, Give Year or Dates:	? [No	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2 🖾 No	lispanic O an, Mexica Specify		cify Yes or No- lican, etc.)	Blac	k, White,	en Indian, etc. an Indian
5	72 hou nature lical E	ted	15. Decedent's Edu (Specify only highest grade	cation		16a. Dece	dent's Usual Occup	ation	at of working		16b. Kind of Bu		
7	within ne.	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired	d) -	ist of workin	9	Mat	_ 1	
N	e filed value of Hygie other to vent, to	e Co	17. Father's Name (First, Middle, Last)	4		1	louse Kee		ner's Name	(First, Middle, I	Mote Maiden Sumam		
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	2 shou and M is mar reumet		19a. Informant's Name/Relationship (Ty		т	1	ng Address (Street						
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Ē	Pages nent of I ant: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)			emetery, crer	natory`or other plac ce Cremat		2/12/		Belts		
Saitimo	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service License	90 N	10038	3 22	Name and Addre	ss of Facil	lity				.,
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XOD	certific		IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome							23d. Date	e of delive	erv erv
	w requires that the death certificate is signed by the attending should be detached for use as	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			Ectopic pregnancy Other (specify)				Мог		Day Year
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>	ysic)	To B	examiner?	lospital: 1   Inpati	ient 2 🗌	ER/Outpatien	t 3 DOA Oth	05			ence 6 100 the	er (Specifi	y) Scene
DIVISION OF	After thung Pa		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injui	ury ay Year)	28b. Time of Injury	Wor			8d. Describe ho	w injury occurr	ed	
	death death ctor: y the f	ficat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Ir	niury - At ho	ome farm str	M 1 □	Yes 2		8f. Location (St	reet and Numb	er or Rura	il Route Number.
5	isi or Attanding Physician: The law is elter death. S. ester death. S. enter death. S. enter death. S. entricete has be ed in by the funeral director, page 2 shed in by the funeral director.	Certification:	4 Homicide determined	building, e	tc. (Specif	y)	cot, raciory, omos			City or Town	, State)	Bi Or Flara	erroute realities,
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fo	edical (	29a. Certifier (☐ ack ord) (☐ ack ord) (☐ Certifying Physical Examilian)	sician: To the best ner: On the basis of and manner st	oi examina	wledge, death	n occurred at the tirvestigation, in my o	ne, date a pinion, de	nd place, as	nd due to the ca d at the time, d	ause(s) and ma ate and place, a	nner as st and due to	tated. the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier	1			29c. Licens	e number		2	9d. Date signed	1 (Month,	Day, Year)
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	7		30. Name and address of erson who co			1 23a) (Type,		nn S	treet	Baltin	more. Ma	arv1s	and 21201
	Sta	ite	31. Date filed (Month, Day, Year)	1	trar's Signa		<b>2</b>			-4101	, 13	y =-C	

			For State	State of Maryland		rtment of He			2006	01.271
	<b>1</b> 3	i e	Registrar  1. Decedent's Name (First, Middle, Las	t)	Cei	uncate of D	Calli	2. Date of Deat	eg. Ne. UUU th	3. Time of Death
2	Physici		TUANITA	.C. Dee	m			_ Month FEBRUAR-	Day Year 7 09 2006	1 A M
	/Medic Examir		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or L	ocation of Death	- CDK-47	4c. County of Dea	
1		50	SINAI 1-105PIT	AL OF BALTIMUR	31	BALTIA	MORE		NI	A
•	Funeral Director		5. Social Security Number  318-48-0489  1  Usual Residence of Decedent	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birth Month, Day July 25	Year) 9. Bir	thplace (State or Foreign buntry)
	land iow		10a. State 10b. County	10c. City,	Town or Loc	cation				10d. Inside City Limits
	within 72 hours after death with the Maryland ene. then "neturel", or iteme 23a or 28a-f ehow ne Mudical Exercites mat be notified at	ctor	MD BALT	More	Owi	NES M	ills			1 Tes 2 No
	or 28	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	ath w		8009 lownship			2111	7		U. S. f	
	er de Item	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	. 13. V	Vas Decedent of His Yes, specify Cuban	panic Origin? (Spo , Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
36	urs aft	byF	1 Never Married 2 Married 3 Widowed 4 Trivorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1	☐Yes 22No	Specify:		Specify: i	hite
21215-0036	"natural", or		15. Decedent's Ed	ucation		ent's Usual Occupat			16b. Kind of Business	
218	thin 7	Completed	(Specify only highest gra- Elementary/Secondary (0-12)	College (1-4or 5+)	(Give I life. E	kind of work done du OO NOT use retired)	iring most of work	ing		
	be filed within 72 ho ital Hygiene. id other then "natur event, the Modical	S	12th	NIA		Clerk			FRS.	
Maryland		Be	17. Father's Name (First, Middle, Last)			1	18. Mother's Name			
<u>\frac{1}{2}</u>	should be and Mental marked o umatic eve	ဥ	HERISERI DES		10h Mailie	a Address (Street or	DOROTH		City or Town, State.	Tin Code
Ma	d 2 in the art treut		HERBERT. B. S	EVERN	3 7			STERS To		21p Code)
ē,	Heal		20a. Method of Disposition	20b. Plac	ce of Dispos	Solution (Name of patory or other place)	1		20c. Location - City or	Town, State
Baltimore,	permit. Pages 1 ar Depertment of Hea Important: if Item eny injury or othe once.		Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Hemoval from State		Ceneter place,	1 16 1 10	106	BALTO. M.	)
alti	Depermit. Depertmitimportal		21. Signature of Funeral Service Licen			Name and Address				,
m	88 58	4.3	faul In.	Stella	TV T	1527 has A	ord Ps.	30 Ho. M	0 21234	
7			23a. Parth. Enter the disease, or composhock, or heart failure. List only	plications that caused the death.						Approximate Interval Between
1	Physician		Immediate Cause (Final disease or condition	a DEEP VEIN	THR	OMBUS				Onset and Death
7.0	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):					9
	**	_	Sequentially list conditions,	b. — Due to (or as a nonseque	ona off-					
7	uted I Insit	al L	tany, leading to minior ato cause. Enter Underlying Cause (Disease or injury	source (et als a condeque						
o î	The taw requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use es the burial-transit	Examiner	that initiated events resulting in death) Last	c.  Due to (or as a conseque	ence of):					
8760	ysicie	dical		d						
9	ntifica ng ph es th	Jed	IF FEMALE:							
Вох	eath certific attending p for use es (	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnance 1☐Live birth 2☐Fetal d		Ectopic pregnancy			23d. Date of de Month	livery Day Year
-	the all	sici	1 ☐ Yes 2 Ø No 9 ☐ Unknown	4 Pregnant at time of dea 9 Unknown	ith 5	Other (specify)			Month	Day real
P.0	that the de led by the detached		Part II. Other significant conditions of	ontributing to death but not result	tina in the un	nderiving cause giver	n in Part I.	23e. Did to	bacco use contribute to	the cause of death?
ds,	ulres sign ld be	Completed by	Dementia		•	, , , , , , , , , , , , , , , , , , , ,		1 🗆 Y	es 2 □ No 3 □ P	robably 4 🗹 Unknown
CO	w require been signature should b	lete	HYPEWATEEMIA					24a. Was a	n 24b Were a	utopsy findings available
Be	The lay	E	_					autops	med? death?	utopsy findings available completion of cause of
ta	sician: Th certificate irector, pag	BeC	25. Was case referred to medical	C E			26. Place of Deat	1 Yes		3 2 □ No
<u>_</u>	nysici nis ce I direc	ToE	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☑ Inpatient 2 ☐ El	P/Outpatien!	3 DOA Other	4 Nursing Ho	me 5 Reside	ence 6 Other (Spe	ocify)
Division of Vital Records,	ding Ph h. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury 2 (Month, Day Year)	28b. Time of Injury	28c. Injury a Work?	at		ow injury occurred	, , , , , , , , , , , , , , , , , , , ,
sio	Attendi er death. rector: A by the fu	Certification:	2 Accident investigation 3 Suicide 6 Could not be				es 2 No			
ΣĬ	or At after of Direction by	art#	4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Si City or Town	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,		29a. Certifier 1 ☐ Certifying Ph	ysician: To the best of my knowl	ledge, death	occurred at the time	a date and place	and due to the o	ause(s) and manner a	s stated.
	e Hos 24 h e Fur	Medical		niner: On the basis of examination and manner stated.	on and/or inv	estigation, in my opi	nion, death occur	red at the time, d	late and place, and du	e to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier			29c. License	number	2	29d. Date signed (Mon	
			1	-M.D		RES	000		F EBRURY	09,2006
	T		30. Name and address of person who							
	10		JUITN NWAINKWO			OF BALT	MURE, 24	OI W BEID	ien fre Ave, 82	HEMORE MO PILLS
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire					

DHMH 17 Rev 1/2001

DEEM

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Month Pay 11, 2006 **Physician** Eckard 9:30 AM Viola /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Dundalk 7618 Meadow Way If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. September 8, 1910 South Carolina 1 ☐ M 2 💢 F 95 249-01-9603 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10h County •how item 27 ie marked other than "natural", or items 23a or 28s-f ebov other traumatic event, the Modical Examinar must be notified at 1 ☐ Yes 2X No Dundalk Baltimore Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 7618 Meadow Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian 11. Marital Status 1 ☐ Yes 2 No 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2√ No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene Own Home Housewife 10 years of Heelth and Mental Hygie Item 27 le marked other I 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be Annie Laura Garrison George Hawkins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 7616 Meadow Way, Dundalk, Maryland Jo Ann Pierro Friend Pages 1 and Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition February permit. Pages
Depertment of the Important: If its any injury or of other 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 15, 2006 Baltimore City, MD. 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PERTEHSION Physician /Medical LOSCUEROTIC CADDIO VASCOLAR

CONSEQUENCE OFF:

ULBR CARCINOMA

DISEASE Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury Examine the death certificate be executed burial-transit and that initiated events resulting in death) Last 68760, attending physician by Physician/Medical use as the Box IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day ğ in the past 12 menths? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. detached P P 9☐ Unknown 9 🗆 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, certificate hes been sign rector, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 € No 24a. Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner? funeral director, 28. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 esidence 6 Other (Specify) Medical Certification: To 1 ☐ Yes \_ 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 1 DNatural Injury 5 Pending investigation 1 Yes 2 No within 24 hours after death.

To the Funeral Director: All completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ၉ Markel-Clace Dindalk who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FFB 1 5 2006 Registrar

			riease	State of Manda				•	
			For State	State of Marylai		ent of Health and ate of Death		4000	04273
	200	-	Registrar  1. Decedent's Name (First, Middle, Last	)	Oertine	le of Death	2. Date of Deat	<b>eg. No.</b> h	3. Time of Death
	Physici		( has	los D.	E	alow	Month	Un 10, 2001	Or m Au
die	/Medic Examir		4a. Facility Name (If not institution, give	street and number)	4b. Ci	ly, Town, or Location of Deat	11	c. County of Dea	
14			2302 Rou	nd Rd. A	pt-A1	Batten	iore	N	IA
	Funeral		5. Social Security Number 6. Se	X 7. Age (In yes	Month	der 1 Year If Under 24 Hrs is Days Hours Min.		Year) 9. Bii	thplace (State or Foreign
	Director		Usual Residence of Decedent	20.	Yrs.		MARIC	1,1925 Pe	msylvania
	land ow		10a. State 10b. County	1 / 10c. C	ity, Town or Location				10d. Inside City Limits
	Many First	ţō	md.	JA	Sa	Itemore			1 XYes 2 □ No
	with the Maryland a or 28a-f show	lrec	10e. Street and Number	. 21	0 / 10f.	Zip Code	1	0g. Citizen of What C	ountry?
	ours after death with the Marylan rel', or Items 23a or 28a-f show Examiner must be mulfied at	Funeral Director	2302 Kn	und Ra.	POTAL	21225		US	4
	or death	nuel	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13. Was De if Yes, s	cedent of Hispanic Origin? (S becify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am Black, Whi	
36	hours after turel', or Ite	by Fi	1 Never Married 2 Married 3 Widowed 4 Qivorced	1 XYes 2 □ No If Yes, Give		2 No Specify:		Specify:	3/och
5-0036	2 3 3	ed	15. Decedent's Edu	Year or Dates:	16a. Decedent's U	sual Occupation		16b. Kind of Business	Andustry
215	thin 72 e. en "nai	plet	(Specify only highest grad Elementary/Secondary (0-12)	(e completed)  College (1-4or 5+)		work done during most of wo	rking	Purit	
212	e filed withir Il Hygiene. other then	Completed	1219	NA	E	ngineer		Be	nnett
pu	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Last)	5-01 )			me (First, Middle, M	Maiden Sumame)	10
yla	should by the should by the should by the should be shou	0		Edlow		ESKL		lenne	e_
Maryland	2 4 4 5		19a. Informant's Name/Relationship (T)			ss (Street and Number or Ri	_		
	s 1 and f Health Itam 27 other tr		Corne LIA D. Glec 20a. Method of Disposition		Place of Disposition (A	Vann Ave . E		Re mals 20c. Location - City or	
по	ages nt of nt of t: if it		1 Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Removal from State	cemetery, crematory of	r other place)		DWINGO MI	46
altimore,	permit. Pages Department of Important: If I eny Injury or once.		21. Signature of Fineral Service Lone	-/		and Address of Facility 2-			
8	Depa Impo eny Ir		Day / 11	net	(50 -	P. march 1	-		
			23a. Party Int with disease, or complished, or head failure. List only of	ications that caused the dea	th. Do not enter the m				Approximate Interval Between
	Priysician		Immedia e Jause (Final disease or Condition		lial Infarc				Onset and Death
	/Medical		resulting in death)	Due to (or as a conse	quence of):				
	Examiner		Sequentially list conditions,	Coronari		Listerse			-8years
7	ed isi	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	uence of):				
V	sician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):				
290	<ul> <li>requires that the death certificate be enbeen signed by the ettending physician should be detached for use as the buria</li> </ul>	calE		1					
89	certificate iding phy se as the								
Вох	h cert endin use	Physician/Med	230. Was decedent pregnant	3c. If yes, outcome of pregn 1 ☐Live birth 2 ☐ Fet	ancy el death 3 Ectopic			23d. Date of de	livery
	death ne etten ed for u	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time of e				Month	Day Year
P.O.	requires that the leen signed by th hould be detache	Phy	9 Unknown						
	res th	by	Part II. Other significant conditions con	ntributing to death but not res	suiting in the underlying	rcause given in Part I.		acco use contribute t s 2 ⊠No 3 □ P	o the cause of death?
0.00	requ	etec	Diabetes Melli	24. C					
Records,	e far has	Completed	n 16 1	743			24a. Was ar autops perform	v prior to	utopsy findings available completion of cause of
Vital	iician: Th certificate rector, pag	e Co	25. Was case referred to medical		_		1 ☐ Yes 2	No 1 ☐ Yes	2 □ No
=	Physician: this certific al director,	To Be	examiner?	lospital: 1 Inpatient 2	ER/Outpatient 3	Othor	th Check only one	nce 6 □Other (Spe	and d
Jo (	g Physe er this eral dir	<u>-</u>	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of	28c. Injury at Work?	28d. Describe ho		icity)
io	Attending I r death. ector: After by the funer	atlo	1 Matural 5 Pending 2 Accident investigation	(WOILI, Day Year)	Injury M	1 ☐ Yes 2 ☐ No			
Division of	r Atta	#	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	nome, farm, street, factify)	ory, office	28f. Location (Str City or Town	reet and Number or R , State)	ural Route Number,
	oital ours at urs at India	Š	V						
	To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Medical Certification;	29a Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	ner: On the basis of examina and manner stated.	cwladge, death comint ation and/or investigation	id at the time, date and place on, in my opinion, death occu	), and due to the ma irred at the time, da	uca(c) and marker a ite and place, and du	e to the cause(s)
	o the ithin ( o the omple	Med	29b. Signature and title of certifier	and manner stated.	2	9c. License number	29	d. Date signed (Moni	ih, Dav, Year)
	⊢s⊢ŏ		> Slarsh	lun		DU035363		Y	
	الاا		30. Name and address of person who co	ompleted cause of death (Ite	m 23a) (Type, Print)	DU035363 Greene St.	0 . 1	1.1	
	NJ.		Sandra Marsh	all mp BVA	MC 10 N	, Greere St.	Baltime	re, MD2	1201
	Sta		31. Date filed (Month, Day, Year) FEB 1 5 20	32 Registrar's Sign	ature Leads				
tolk	Registr	ar	LED 1 9 70	UU MARKEN S	Contraction of the second				

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 0 0 6

			For State Registrar	State of Mar	-		ment of H iicate of I		_	Reg. No.	06	04275
	Q		Decedent's Name (First, Middle, Last)						2. Date of De		Year	3. Time of Death
	Physicia /Medic		Clyde Marie Edward						Februo	ry 1.	2006	10:35 PM
	Examin	er	4a. Facility Name (If not institution, give	1 1	Jame	41	o. City, Town, or	Location of Death		A 4	a Cfo	
-	Funeral		5. Social Security Number 6. Sex		In yrs. last birt		Under 1 Year	De 600 If Under 24 Hrs.				place (State or Foreign
	Director		218-32-6837	M 2X)F 8	7	Yrs.	onths Days	Hours Min.	8. Date of Birt ( <i>Month</i> , <i>Da</i> 12/22/	1918	Nor	nplace (State or Foreign Intry) th Carolina
	and		Usual Residence of Decedent  10a. State 10b. County	1	Oc. City, Town	n or Locati	on					10d. Inside City Limits
	Maryl -f sho	tor	MD Harkord	1	Havre	do	Grace				1	1 XYes 2 □ No
	th the	irec	10e. Street and Number	<u> </u>	1100,00		10f. Zip Code			10g. Citizen	of What Cou	untry?
	23a c	Funeral Director	4007 Chapel Road				21078			USA		
	er de	une	11. Marital Status  1 ☐ Never Married 2 ☐ Married	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was	Decedent of Hi es, specify Cuba	spanic Origin? (Spe n, Mexican, Puerto I	cify Yes or No Rican, etc.)	- 14.1	Race - Amer Black, White	
036	urs aff	ξ	3 Widowed 4 Divorced	1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		1 🗆	Yes 21X No	Specify:		Spe	ecity: Whi	te
5-0(	72 hor	Completed	15. Decedent's Edu (Specify only highest grade	cation e completed)	16a.	Deceden	's Usual Occupa	ation during most of workin	na	16b. Kind o	of Business/li	ndustry
121	within ne. han "	mple	Elementary/Secondary (0-12)	College (1-4or 5+)						Sh	oe Com	WANA
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "neturel; or Itams 23a or 28e-f show raumatic event, the Medical Examinet must be mittled at		8th 17. Father's Name (First, Middle, Last)		T	acro	ry Work	18. Mother's Name	(First, Middle,			iparig
lan	uld ba fental rked c	To Be	Charles Clayton Wo	igoner				Grace An	drews			
ary	2 shou and N Is ma		19a. Informant's Name/Relationship (Ty	pe, Print)		-	•	and Number or Rura			wn, State, Z	ip Code)
%	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "netural; or Itams 23a or 28e-f show any injury or other traumatic event, Ita Medical Examination or other or other traumatic event.		Keith Edwards - Sol					urt, Bel	Air, MI		14 ion - City or T	Four State
Baltimore,	ages on the property of the pr		1 ☐ Burial 2 ☐ Cremation 3 💢 🗏	emoval from State		-	on (Name of ory or other plac					
菲	nit. Py artme ortani injury		<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service License</li></ul>	98	Sparta			02/0! ith Funer				th Carolina
B	permi Depar Impor any ir		Strainen.	5mit	8	123	neck-Sm S. Wash	ington, H	ac nome lavre de	e, P.A e Grac	e. MD	21078
			Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the	e death. Do r	not enter t	ne mode of dyin	g, such as cardiac o				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	Coro	nan	1	Mir	y De	scal	e		Onset and Death
	/Medical Examiner		Testing in death,	Due to (or as a o	consequence	of):						U
		ler	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	consequence	of):		•				
V	executad in and ial-transit	Examiner	that initiated events	). <sub></sub>								
90,	ba exe ician a burial-l		resulting in death) Last	Due to (or as a d	consequence o	of):						
68760,	rtificate ba executad ng physician and as the burial-transit	edicai		1								
Box (	n cartif anding usa a		IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outcome of 1 Live birth 2		205-	topic pregnancy			23d.	Date of delin	very
. B	sicien: The law raquiras that the death car certificate has baen signed by the attendin rector, page 2 should be detached for usa	Physician/N	in the past 12 months? 1 □ Yes 2 ☑ No	4☐Pregnant at tin			her (specify)				Month	Day Year
P.O.	raquiras that the aen signed by th nould be detache		9 ☐ Unknown  Part II. Other significant conditions cor		not resulting in	the unde	riving cause give	an in Part I	23a. Did t	obacco use o	contribute to	the cause of death?
ds,	uiras t signe id be c	d by						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		Yes 2.DXN		bably 4 Unknown
4 de ecords,	w raq s baen shou	Completed	Malnutali Afrial by	Preneal	in	_	•		24a. Was	an 24	4b. Were au	topsy findings available ompletion of cause of
₹ Se	The la te has	omp							autor perfo	osy rmed? 2. <b>X</b> No	death?	ompletion of cause of 2 No
ital (	zien: artifica ctor, p	BeC	25. Was case referred to medical examiner?					26. Place of Death				
S	Physic this co	은	1 ☐ Yes 2 KNo		2 ER/Ou	tpatient	3□ DOA Othe	4 Nursing Hon	ne 5 🗆 Resid			ify)
/	iding Physip. Ih.: After this funeral di	Certification:	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	/ear) II	njury	Worl	(? Yes 2 □ No	.og. Describe i	iow injury oc	Culled	
ward	Attending sr death. ector: Aite by the fune	ifica	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	- At home, fa	rm, street	factory, office	2	28f. Location (3		umber or Ru	ral Route Number,
Ed ward Division	ospitel or Attend hours after death unerel Director: ly filled in by the							Į.				
五	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medicel Exami	sicien: To the best of a ner: On the basis of ea and manner state	xamination an	death od dor inves	curred at the tin tigation, in my o	ne, date and place, a pinion, death occurre	and due to the ed at the time,	cause(s) and date and pla	d manner as ice, and due	stated. to the cause(s)
	ro the vithin to the comple	Mec	29b. Signature and title of certifier		-		29c. License				gned (Month	ı, Day, Year)
			> 1Wman	, ms			D3	2607		2/2/	06.	
	3		30. Name and address of person who co	impleted cause of dea	th (Item 23a)	(Type, Pri	(II)	et Hour	re Du l	Or all	300	21/20
	Sta	10	31. Date file of poppy, pay 50 9776	amplated cause of dea	sanature	TOV.	o chilling	-1	, 42 6	10 4	,,,,D	×10/8
	316	110	F F R ( ( ') 711116	# 363 att . 400 -	ALAPI ARRIVA	The Party of						

Registrar

				For State Registrer	State of Ma	ryland / Depa <i>Cel</i>	artment of H		lental Hygie Reg.	21116	04276	
				Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death	
		Physici /Medio		Leonard Garfield Ed	wards				Februar	Day 7 Year	6 3:15 PM	
		Examin		4a. Facility Name (If not institution, give si			4b. City, Town, o	r Location of Death		4c. County of De	ath	
				Harford Memorial Ho				le Grace	Harford			
		Funeral		5. Social Security Number 6. Sex	7. Age M 2□F	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) (	rthplace (State or Foreign country)	
		Director		Usual Residence of Decedent		82 Yrs.			10/18/19	23 Nor	th Carolina	
		land		10a. State 10b. County		10c. City, Town or Lo	cation	<del></del>			10d. Inside City Limits	
		ith the Marylar or 28a-f ehow se notified at	ğ	MD Harford		Churchy	1000				1 X Yes 2 □ No	
		r 28a	rec	10e. Street and Number		chatcho	10f. Zip Code		10g.	Citizen of What C	country?	
		h with	0	3419 McCommons Road			21028		_ u	ISA		
		after death with the Maryla or iteme 23a or 28a-f ehov miner must be notified at	Funeral Director	11. Marital Status	2. Was Decedent E Armed Forces?	ever in U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto		14. Race - Am Black, Wh		
	9	or its	F	1 Never Married 2 Married	1 TYes 2 □ N	lo	1 ☐ Yes 2 🛣 No	Specify:	ricari, otc.)	Specify:	ne, etc.	
	8	ure!,	d by	3 Widowed 4 Divorced	Year or Dates:	1943-45				a	hite	
	15	"net	ete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Dece	dent's Usual Occup kind of work done	ation during most of worki d)	ng 16b	b. Kind of Busines	s/Industry	
	12	within iene. then		Elementary/Secondary (0-12)	College (1-4or 5 2 year)	+)		., Technici		I.S. Gove	h tama ta t	
-	9	be filed within 72 hours after death with the Maryland tal Hyglene. d other then "neturel", or Iteme 23a or 28a-f ehow event, the Medical Examinar must be mutilled at	Be Completed	17. Father's Name (First, Middle, Last)	z gewo.	S CIR	ineering		(First, Middle, Maid		runera	
5	au	id be ental ked c	To B	Hurley W. Edwards				Pollu R	ichardson			
5	Maryland 21215-0036	2 should be f and Mental ? ! le marked of reumatic eve	-	19a. Informant's Name/Relationship (Typ	e, Print)	19b. Mailir	ng Address (Street	and Number or Rura			Zip Code)	
1		s 1 end 2 should be filed within 72 hours if Health and Mental Hygiene. Item 27 Ie marked other then "neturel", other treumatic event, the Medical Exe		Billie B. Edwards-	Wife	3419 1	AcCommons	Rd., Chu	rchville.	MD 2102	8	
	Baltimore,	s 1 end 2 of Health Item 27 I		20a. Method of Disposition		20b. Place of Dispo cemetery, crei				. Location - City o		
	E	permit. Pages Depertment of I Important: If Ite eny injury or of		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1		s. 02/13	106 Be	l Air, M	aruland	
	ati	permit. Depertrimports eny inju		21. Signature of Funeral Service License			Name and Addre	es of Facility				
	Ω	8858		Saraure m	mc.	4 72	3 S. Wasi	nith Fune hington, t	lavre de (	Grace. Mi	21078	
8				23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	cations that caused e cause on each lin	the death. Do not entile.	er the mode of dyin	ng, such as cardiac o	or respiratory arrest,		Approximate Interval Between	
0		Pnysician		Immediate Cause (Final disease or condition	carde	ac arre	25+				Onset and Death	
0	1	/Medical		resulting in death)		a consequence of):						
1		Examiner		Sequentially list conditions.			n Farch	ro~				
3	7	D #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence of).						
	•	and and I-tran	Хащ	that initiated events resulting in death) Last	Due to for as	a consequence of):						
	8760,	cate be executed bhysicien and the burial-transit			200 10 (01 03	2 00/130440/108 01).						
	387	phys the	dical	d.							1	
0	9 x	eath certific ettending p for use as	/We	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of d	alivon	
4	Bo	eath etter for u	Ciar	in the past 12 months?		2 Fetal death 3	Ectopic pregnancy Other (specify)	1		Month Month	Day Year	
Q	Ö	thet the ded by the detached	Syc	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown							
0	s, P	s thet ned b	Completed by Physician/Me	Part II. Other significant conditions con-	tributing to death be	ut not resulting in the u	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute	to the cause of death?	
ij	ords	quires n sign	De De	anoxic brain	12000	<b>_</b>			1 ☐ Yes	2 □ No 3 □ F	robably 4 dunknown	
	ပ	aw requir ss been s 2 should	Siet	acute renal	failure				24a. Was an	24b. Were	autopsy findings available completion of cause of	
0	Re	The Is	E	unger FT	blead				autopsy performed 1 ☐ Yes 2 ☐	d? death?	completion of cause of	
P	Vital	ilcien: Th certificete rector, pag	BeC	25. Was case referred to medical	BICOR	I district		26. Place of Death	Check only one	rivo i la ie	5 2 10	
5		ysicien: is certific director,	2	examiner?	ospital:	nt 2 ER/Outpatier	nt 3 DOA Oth		me 5 ☐ Residenci	e 6 □Other (Sp	ecify)	
3	n of	ding Ph J. After th funeral		27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injui	y Year) 28b. Time o	f 28c. Injur Wor		28d. Describe how i			
J	Division	ottendin death. ctor: Al y the fu	Certification:	2 Accident investigation				Yes 2 □ No				
1	Ξ	efter de Direct	Ę	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ury - At home, farm, str c. (Specify)	28f. Location (Stree City or Town, S	et and Number or I State)	Rural Route Number,			
		ST E DE		00.0.4	1		· · · · · · · · · · · · · · · · · · ·					
		Hospital     24 hours e     Funeral i letely filled	Medical	29a. Certifier ← Certifying Phys (Check only 2 Medical Examin	er: On the basis of	of my knowledge, deat examination and/or in	h occurred at the till vestigation, in my o	me, date and place, a opinion, death occurr	and due to the caus ed at the time, date	e(s) and manner a and place, and di	is stated. ie to the cause(s)	
		i i i i	Mec	29b. Signature ap Offile of certifier	and manner sta	nou.	29c. Licens	se number	29d.	Date signed (Mo	nth. Dav. Year)	
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		1 de An	2							
		(.0)		30. Name and address of person who con	moleted cause of d	eath (Item 23a) (Type,	Print)	3666	re	pryam	4 2006	
		(10)		Paul Little DO	501	S. UNION	Are	5222 Houre I	2 brace	e MD		
		Sta	ate	31. Date filed (Month, Day, Year)	32 Registra	ar's Signature	2000	•				

State of Maryland / Department of Health and Mental Hygiene

01,277

Physician
/Medical
Examiner

 $_{\varepsilon}$ Funeral Director

permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depentment of Health and Mentel Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificete be executed within 24 hours effer death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be deteched for use es the buriel-trensit

Chester R. Evans Sr.  **Really Name (If not institution give street and number)**  **Severna Park Center**  **Severna Park Center**  **Severna Park Center**  **Severna Park Center**  **Severna Park Center**  **Severna Park Center**  **Pin 2   Farge (In yes, last birthday)**  **Pin 2		Cer	tificate of	Death		Re	eg. No.	, ,	0 1 1 1
Recipt Varies for in institutions of the street and screening of the company of t	Decedent's Name (First, Middle, Last)				2			Voor	3. Time of Death
a Racisty when of nor institution, give shores and number)  Severna Park Center  Severna Park Center  Severna Park Anne Arundel  Severna Park  Anne Arundel  Severna Park  Anne Arundel  Severna Park  Anne Arundel  Severna Park  Anne Arundel  Severna Park  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  Severna Park  It Unional Year  It Unional Year  Severna Park  It Unional Year  It Unional Year  It Unional Year  Severna Park  It Unional Year  It Wear  It Unional Year  It Wear  It Unional Year  It Unional Year  It Unional Year  It Union	Chester R. Evans Sr.	•			न				12noon
Severna Park  Severna Park  Anne Arundel  12	a. Facility Name (If not institution, give street and numb	per)		4b. City, Tov			_		
Social Security Number 20 - 10 - 41		•		Sovo	rna	Park	Ann	- Arı	ındel
In State   Inc. County   MD   Anne Arundel   Severna Park   Inc. Colly, Town or Location   Inc. Colly   Inc.		Age (In ure last hirthday)	If Under 1 Year						
Anne Arundel   10c. Cety, Town or Location   10d. Indice Cety   10d. Cety   10	t M 2 F	Van			Min.	(Month, Day,	Year)		
As Babe 100. County ID Anne Arundel 100. City, Town or Location Severina Park  101. Zp Code 101. Zp Code 102. Zp Code 103. Zp Code 103. Zp Code 104. Zp Code 105.		87				7-25-1	910	Mary	land
March Point Drive  10. Zip Code 21012  10. Citizen of What Courtry?  USA  Martial Status 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. What Depotent Per in U.S. 11. Never Married 2 M Married 12. Never of Classes 12. Never of Classes 13. Never Married 2 M Married 14. Never of Classes 15. Depotent Per Sounds 16. Never of Classes 16. Never of Classes 17. Never of Classes 18. Never of Classes 18. Never of Classes 19. Never Married M Married Per Never Office Specific Married		10c. City, Town or Loc	ation					10	Od. Inside City Lim
as Street and Number 790 Match Point Drive 107. 20 Code 790 Match Point Drive 108. 21012 109. College of What Country? 109. Match Point Drive 109. Match Point Drive 119. Mass Decedent Ever in U.S. 110. New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 28 Mannied 110 New Married 29 Mannied 110 New Married 29 Mannied 110 New Same President Program 19 New 28 New Sepecity 110 New Same President Program 19 New 28 New Sepecity 110 New Same President New New Same New New Same President New New Same New New New Same New New Same New New Same New New Ne	MD Anne Arundel	Severna	Park						1 □ Yes 2 🛣 I
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Marrial Status   12   Was Dispedent Ever in U.S.   13, Wes Dispedent College (February Chief)   14, Rec American Indian, Blanch College (February Chief)   15, Decedent of Hispanic Chief)   16, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent of Hispanic Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief, Decedent Chief		70		21012		1"	-	wnat Coun	try?
Comment   Comm	790 Match Polit Dil								
Comment   Comm	. Marital Status 12. Was Decede Armed Force	ent Ever in U,S. 13. Ves?	Vas Decedent of F Yes, specify Cub	lispanic Orig an, Mexican	gin? (Specii , Puerto Ric	y Yes or No- can, etc.)			
15a. Decedent's Evadation Coupside (Speech) only highest grade completed)   15a. Decedent's Evadation (Coupside (National Coupside (National Cou	If Yes, Give	₹ No							
Specify only highest grade completed   Callege (1-4or 5+)   Truck Driver   News American   News American   Truck Driver   News American   Ne	3 ☐ Widowed 4 ☐ Divorced Year or Date						Opecii	у.	
Truck Driver  Truck Driver  Truck Driver  Truck Driver  News American  18. Mother's Name (First, Middle, Last)  Wood Evans  19. Informant's Name (First, Middle, Last)  19. Malling Address (Street and Number or Fural Floute Number, City or Town, State, Zep Code)  74.17 Pucks Haven Lane £ighland, MD 20777  All Donation 5. Glober (Specify)  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  19. Signature of Pureral Service Lossans  20. Constitution City or Town, State of each in the Constitution City or Town, State of each in the Constitution City or Town, State of each in the Constitution City or Town, State of each in the Constitution City or Town, State of Each in the Constitution City or Town, State of Each in City or Town, State of	15. Decedent's Education	16a. Deced	ent's Usual Occup	ation	t of working		16b. Kind of B	usiness/Inc	lustry
Truck Driver   Truck Driver   News Aller Call		or 5+)			. J. HUINIIY		N7	7	
Remorts Name (First, Middle), Madden Sumanne)   Removal First, Middle), M		Truc	ck Driv	er			News /	amer:	ıcan
19b. Malling Address (Street and Number or Rural Route Number. City or Town. State. Zip Code)   74.17   Bucks Haven Lane Highland, MD 20777   20b. Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Place of Disposition (Name of Agronium Place of Disposition (Name of Agronium Place of Disposition (Name of Agronium Place of Disposition Place of Disposition (Name of Agronium Place of Disposition Place of D		···		18. Mothe	r's Name (/	irst, Middle, N	Aaiden Surnar	ne)	
A Method of Disposition   20th Piece of Disposition (Name of of Cementors)   20th Piece of Disposition (Name of of Cementors)   20th Piece of Disposition (Name of Order piece)   2/16/06   Baltimore, MD   2/16/06   Baltimore, M	Wood Evans			Ber	cth B	rokem	arkle		
A Nethod of Disposition   200. Place of Disposition (Name of Committee of Disposition (Name of Committee of Disposition (Name of Committee of Disposition (Name of Committee of Order place)   200. Location - City or Town, State   200. Location - City or Town, State   2/16/06   Balltimore, MD	Pa. Informant's Name/Relationship (Type Print)	n 19h Mailin	a Address /Street	and Numbe	er or Rural F	Route Number	City or Town	State Zin	Code)
a. Method of Disposition   Section							•		•
AS Butial 2 Cremation 3 Chamber (Specify)  Cardens of Faith 2.16/06 Baltimore, MD  Cardens of Faith 2.216/06 Baltimore, MD  Signature of Juneral Service Licensess  22. Name and Address of Facility Joseph N. Zannino Jr.FH  263 S. Conkling St.Baltimore, MD 21224  28. Part. Enter the disease, or or ormplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased shock, or heart failure. List only one cause on each line.  CONCESTIVE CALDIOMYOPATHY  YEALS  29. Name and Address of Facility Joseph N. Zannino Jr.FH  263 S. Conkling St.Baltimore, MD 21224  As Part. Enter the disease, or ormplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, increased th				aaven					
Signature of Junetal Service Licepses   22. Name and Address of Facility   Joseph N   Zannino   Jr. FH   263 S. Conkling St. Baltimore, MD   21224		ate cemetery, crem	atory or other pla		l l			•	
263 S. CONKling St. Baltimore, MD 21224  Approximate the disease or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, broker, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause on each line.  Approximate the shock, or heart failure. Lief my one cause of the shock, or heart failure. Lief my one cause of the shock or heart failure. Lief my one cause of the shock or heart failure. Lief my one cause of the cause o		Gardens	of Fai	th	[2]	16/06	Balt:	imore	e, MD
263 S. CONKLING St. Baltimore, MD 21224  AB PART. Enter the disease, or or miplipations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Betwee Onset and Deat Shock, or heart fallue. List righty or eause on each line.  Approximate sease or conditions, and the conditions are conditions.  Approximate the disease, or or miplipations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Betwee Onset and Deat Shock, or heart fallue. List righty or eause on each line.  Approximate the disease, or or miplipations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interest Betwee Onset and Death Well and Death of the Conditions are conditions. In the conditions are conditions, and the conditions are conditions.  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  1   Yes   2   No   3   Probably   4   4   4   4   4   4   4   4   4	. Signature of Funeral Service Licensee	22.	Name and Addre	ss of Facility	Jos	eph N	Zanı	nino	Jr FH
3a. Part I. Enter the diseage, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe friends all believe from the friends all believe friends all b	> // hand // 2/5	26	3 S. C	onkli	ng S	t.Bal	timore	e.MD	21224
d.    Continued of the contributing in death but not resulting in the underlying cause given in Part I.   23b. Did tobacco use contribute to the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the countribute of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of the cause of death   1   Ves 2   No 3   Probably 4   Aunited of the cause of t	any, leading to immediate ause. Enter Underlying ause (Disease or injury	Due to (or as a consequ	uence of).						
1   Yes 2   No 3   Probably 4   Aunion	at initiated events	Due to (or as a consequ	ience of):						
24a. Was an eutopsy performed?  24b. Were autopsy findiavailable prior to completion of caus of death?  1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   1   Yes   2   No   Nursing Home   5   Residence   6   Other (Specify)   Yes	art II. Other significant conditions contributing to deat	h but not resulting in the un	derlying cause giv	en in Part I.	3.5	23b. Did to	bacco use co	entribute to	the cause of dea
24a. Was an eutopsy performed?  24b. Were autopsy findiavailable prior to completion of caus of death?  1 Yes 2 No 2 Yes 2 No 2 Yes 2 No 2 Yes 3	_					1 □ Y	s 2 No	3 Prob	ably 4 Unkn
Available prior to complete to of caus of death?    1   Yes   2   No	1) HUEDES MELL	IINS T	180 Z						
Solution   Continuo						24a. Was a perform	n eutopsy ned?	ava	ilable prior to appletion of cause
Solution   Continuo						1□ Ye	s 2 No	1□	Yes 2□No
examiner?    Solution   Hospital:   Impatient   2 ER/Outpatient   3 DOA   Other:   Nursing Home   5 Residence   6 Other (Specify)	Was case referred to medical			26 Place	of Death "		-	1	
Manner of Death   2   Et/Outpatient   2   Et/Outpatient   3   DOA   42   Nursing Home   5   Residence   6   Other (Specify)	examiner?		Oth	or.				(0	4
2   Accident 3   Suicide 4   Homicide  a. Certifier (Check only one)  b. Signature and address of person who completed cause of death (Item 23a) (Type, Print)  M   1   Yes 2   No    1   Yes 2   No    28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  (City or Town, State)  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.  28f. Location (Street and Number or Rural Route Number, of the cause (s) and manner es stated.	TLI Tes ZIA NO TLI IND		3L DOA	4CI NUI	-				"
A Homicide    A Homicide   A Ho	1 Natural 5 Pending (Month, 2 Accident investigation	Day Year) Injury	M 1 🗆		No				(0
(Check only one)  2   Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated.  29c. License number  29d. Date signed (Month, Day, Year)  FXRUARY 13 2c.  Name and address of person who completed cause of death (Item 23a) (Type, Print)  B. C. WALLACE	determined 286. Place of	i Injury - At home, farm, stre , etc. (Specify)	et, factory, office		281	City or Town	reet and Numi i, State)	ber or Rura	i Houte Number,
Name and address of person who completed cause of death (Item 23a) (Type, Print)  B.C. WALLACE  B.C. WALLACE  The state of the state of	(Check only 2 Medical Exeminer: On the basi	s of examination and/or inv							
O. Name and address of person who completed cause of death (Item 23a) (Type, Print)  9005 KURRING RD RAITIMORE MD 7.12-21	Do. Signature and title of certifier	lud			6		_		-
IVV - I-I WARTINE I'M DELWINIVOTON DIVIN WIND II.	). Name and address of person who completed cause of the state of the		Print)			B.	C.Wi	ALLAC	EMD.

DHMH 16 Rev 6/95

Sta Registr

			1- For State of Maryland / Department of Health and Mental Hygiene Certificate of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Day Year Year
	/Medic	al ]	LARRY J. FOXWELL  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Examin	ier	4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death  4c. County of Death  4d. County of Death
	Funeral	2	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign
L	Director		210.62-7808 July 16,1953 MV)
	ow ow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	ith tha Marylar or 28a-f ehow	tor	MD N/A BALTIMORE 1/2 Yes 2 NO
	ith the	Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	s 23a	erall	3878 Everbreen ave 21206 U.S.A.
(0	n 72 hours after death with the Maryle "neturel", or tlems 23e or 28e-f ehov officel Exembler must be notified at	Funeral Director	11. Marital Status  12. Was Decedent Ever in U.S. Amed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.
036	ral, o	by	3 □ Widowed 4 □ Divorced If Yes, Give Year or Dates: 1 □ Yes 2 □ No Specify: Specify: Loh. Te
215-0036	tiled within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f ehow thi, the Modical Examination molified at	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working
212	withir iene. than	dwc	Elementary/Secondary (0-12) College (1-40r5+)  12+4  NA  DISH WASHER  RESTARAUNT.
	a tiled Il Hygi other	Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surmame)
ylar	should be tiled withir and Mental Hygiene. s marked other than sumatic event, It e M.	To E	Weldon Foxwell, SK Thelma Mc Common
Maryland	S as a		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
	ges 1 and 3 t of Heelth if item 27 or other tra		ANNAMARIC WILLIAMS 5905 LILLYAN AVE BALTO MO 21306  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town, State
altimore,	9 = 5 5 = 5		1 Burial 2-Termation 3 Removal from State BAYVIEW Crematory or other place) 2 9 06 BAYVIEW Crematory
altii	parmit. Pag Department Important: I any injury o		
8	20 E 8 8		21. Signeture of Funeral Service Licensee  Paul STELLA  Paul STELLA  TS 27 has Ford RD  Bolto. MD 2 1234
			23a. Parfl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between
	Pnysician /Medical		disease or condition resulting in death)  a. SOUMMONS CELL CA OF MEAD TVECK
	Examiner		Due to (or as a consequence of):
	₽ ≅	ner	Sequentially list conditions, b. tual to (or as a consequence of) cause. Enter Underlying
p	ba executad sician and burial-transit	Examiner	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):
8760,	ate ba ey hysician he buria		Sub-to-(of as a consequence of).
687	titicate ig phys as the	ledic	0.
Вох	leath certitics attending pl	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy  Month Day Year
0.	The law requires that the death certificate ba executed to has baan signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	In the past 12 months?  1   Yes 2   No 9   Unknown 9   Unknown 9   Unknown   Month Day Year
٥.	res that lhe de igned by the be detached		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?
rds	w requires baan sign should be	ed by	1 Yes 2 No 3 Probably 4 DU-Known
ecords,	e law requ has baan je 2 shoul	Completed	24a. Was an autopsy findings available prior to completion of cause of
<u>=</u>		Com	autopsy prior to completion of cause of performed? performed? 1 yes 2 1 do 1 dry s 2 1 dry s 2 1 dry s
Vital R	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital:
of		): To	27. Many of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred
ion	Attending F r death. ector: After by the funer	atior	1 Natural 5 □ Pending (Month, Day Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No
Division	i or Attene atter deatl Director: I in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office City or Town, State)
	pital o		200 Continue At Continue Deviation Total
	e Hos 24 ho e Fun etely t	edical	29a. Certifier  (Check only one)  12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the Hospital or A within 24 hours atter To the Funeral Directompletely tilled in by	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
)			DJ772+ 2/7/06
	7		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nonendy Sharry 2 Monthet Place Dundalh MD21222
	Sta	te	31. Date filed (Month, Day, Year)   22. Registrar's Signature
K. t.	Registr	-	FEB 1 5 2006 A Secretary

			1 - For State Registrar	State o	f Marylar	-		of H	ealth a		•		006	04279		
	Physici /Medi		Decedent's Name (First, Middle     MARION K. FANCHER	•							2. Date of De Month 2	Day	2006 <sup>Year</sup>	3. Time of Death 8:35p M		
	Examir		4a. Facility Name (If not institution,	give street and nur	nber)		4b. City, T	Town, or	Location of	of Death		4c.	County of Dea	ith		
135	c ký		Laurel Regional H	· · · · · · · · · · · · · · · · · · ·			Laur						rince Geo			
	Funeral Director		5. Social Security Number 100-22-7259	6. Sex 1 ☐ M 2 🖾 F	7. Age ( <i>In yr</i> s. 75	Yrs.	If Under 1 Months	Days	If Under: Hours	Min.	8. Date of Bi (Month, D	ay, Year)		thplace (State or Foreign ountry) York		
	land ow		Usual Residence of Decedent 10a. State 10b. County	<u> </u>	10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits		
	Mary a-f eh	tor	Maryland Prince	Georges	Laui	rel								1X∏Yes 2☐No		
	h with the 23a or 28 at be not	Funeral Director	10e. Street and Number 3359 01d Lyne Ave.	The second secon			10f. Zip (	Code )724					zen of What Co			
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or iteme 23a or 28a-f show aumatic event, the Madical Examinar rough be notified at	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 🛣 Widowed 4 ☐ Divorced	Armed Fo	2 [X]No		Was Decede f Yes, speci 1 Yes 2		spanic Orig n, Mexican Specify:	gin? (Spec i, Puerto F	offy Yes or Ne	0-	14. Race - American Indian, Black, White, etc. Specify: White			
Maryland 21215-0036	thin 72 hou e. an "nature Wedical E	Completed	15. Decedent' (Specify only highes Elementary/Secondary (0-12)	s Education grade completed) College (1	-4or 5+)	(Give	ient's Usual kind of work DO NOT use	k done d	lurina most	of workin	g	16b. Kii	nd of Business	Vindustry		
2	ygien ygien her th	Соп	12		,	Homer	maker						Home			
/land	uld be fii Mental H Irked ott	To Be	17. Father's Name (First, Middle, L John Myers	ast)					18. Mothe		(First, Middle	, Maiden	Sum <b>am</b> e)			
Mary			19a. Informant's Name/Relationsh Salvatore M. Cremon	, , ,							Route Numb		Town, State,	Zip Code)		
	s 1 and if Health item 27 other to		20a. Method of Disposition	-,	1 6	Place of Disposemetery, cren	sition (Nami	e of	-		ite		cation - City or	Town, State		
Baltimore,	Pages tment of tant: If it jury or o		1X Burial 2 Cremation 4 Donation 5 Other (Sp	ecify)		Mary's C	emetery	y		2/10/			rs, New	York		
Bal	permit. Departm Imports eny inju		21. Signature of Funeral Fervice L	E Me	Mr.	76	. Name and 501 San	dy Sp	s of Facility Oring F	y Flec Road L	k Funer aurel,	al Hom Maryla	ne nd 20707			
	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):													
	/Medical Examiner			Due to (		uence of):										
B	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a conseq	uence of):										
8760,	ate be executed hysicien and the burial-transit	Ical Exa	resulting in death) Last		or as a conseq Obstruct											
0	tificate ng phy as the			u												
O. Box	the death certificate the attending phys ched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12,months? 1 □ Yes 2 □ No 9 □ Unknown		nth 2 ☐ Feta ant at time of d	Ideath 3 🗌	Ectopic pre					2	3d. Date of de Month	livery Day Year		
2	res that the de signed by the a be detached f	by Ph	Part II. Other significant condition	s contributing to de	ath but not res	ulting in the un	iderlying car	use give	n in Part I.		23e. Did 1	obacco us	se contribute to	the cause of death?		
ecords,	w require been sig should b										1 (X)	Yes 2	]No 3∏Pr	robably 4 □Unknown		
Y	The la	Completed									24a. Was auto perfo 1 \( \text{Yes} \)	psy ormed?	prior to death?	utopsy findings available completion of cause of 2 No		
Vita	Physician: r this certifica ral director, p	Be	25. Was case referred to medical examiner?	Hospital:				Othe			Check only					
ō	his I d	n: To	1 Yes 2 XNo 27. Manner of Death	1 🕰 1 1	npatient 2   f Injury n, Day Year)	ER/Outpatient 28b. Time of		c. Injury Work	7 [] [40]		e 5 Resi		Other (Spe	cify)		
	Attending or death. ector: After by the fune	atlo	1 XXVatural 5 Pending 2 Accident investiga	ition	n, Day Year)	Injury	М		? ′es 2 □ N	10						
DIVISION	2 4 7 6	Certification:	3 Suicide 6 Could no 4 Homicide determin	ed 286. Place	of Injury - At hog, etc. (Specify	ome, farm, stre y)	eet, factory,	office		28	Bf. Location ( City or To			ural Route Number,		
	To the Hospitel of within 24 hours af To the Funerel D completely filled in	edical	29a. Certifier 1 X Certifying (Check only one)	Physician: To the carniner: On the ba and mann	sis of examina	wledge, death tion and/or inv	occurred at estigation, i	t the time n my opi	e, date and inion, deati	f place, an	nd due to the d at the time,	cause(s) added	and manner as place, and due	s stated. to the cause(s)		
	To th To th comp	Me	29b. Signature and title of certifier	7				License					signed (Mont	h, Day, Year)		
	VD.	į	30. Name and address of person w	mpleted cause	of death (Item	1 23a) (Type, F						L/ 13	, 2000			
	10		E. Pasmanik 1420				Laurel	, Mar	yland	20707						
10 mg	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 1 5	- A	gistrar's Signa	ture	3460									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Bepartment of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No." 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death I-LEISHMAH FLORENCE 1:30 P M FEBRUARY 09 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Randalls town Northwest Hespital Baltinone 7. Age (In yrs. last birthday) If Under 1 Year | ff Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 205 6. Sex Birthplace (State or Foreign Country) 1□ M 2☑ F 219-42-6805 97 Yrs. 5-23-08 PA Usual Residence of Decedent 10a. State MD 10b. County 10c. City, Town or Location 10d. fnside City Limits 1 ☐ Yes 2 No MDF BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 725 MT. WILSON LANE #803 21208 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 💢 No 1 ☐ Yes 2 No WHITE Specify ff Yes, Give '\' Year or Dates: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0.12) 12College (1-4 or 5+) STENOGRAPHER SOCIAL SECURITY 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) WASMAN FLEISHMAN SADIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HODES, ULMAN, PESSIN, KATZ, P.A. 901 DULANEY VALLEY ROAD #400 - TOWSON, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State CHIZUK AMUNO ARLINGTON 2/14/2006 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service 8900 REISTERSTOWN ROAD - PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBROVASCULAR ACCIDENT disease or condition resulting in death) a ACUTE Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknowh Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Dunknown CARDIOMYORATHY 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No FIBRILLATION 24a Wasan ATRIAL ormed? 22 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospitaf: 1 I patient Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: The law requires that the death certificete be executed Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ir than "naturel", or items 23a or 28a-f ehow the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ant: if Item 27 is marked other than "naturel; or ite ury or other traumatic event, the Mudical Examina

permit. Pages 1 Depertment of H Important: If its eny injury or ot once.

Physician

/Medical

Examiner

eftending physicien and for use as the burial-transit

certific

fhis After fhi

within 24 hours after death.

To the Funerel Director: A completely filled in by the fu

Examine

Physician/Medical

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Be Completed

Certification: To

Medical

Baltimore, Maryland 21215-0036

Directo

Funeral

Completed by

Be

State Registrar 7H4SICIAN

29c. License number D 42723

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

30. Name and add as of person who completed cause of death (Item 23a) (Type, Print) NORTH WEST HARISH OLD COURT 5401

HOSPITAL

09 2006 CENTER.

AVVERAHALL 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 Homicide

29a. Certifier (Check only one)





					H. Ensure All Copi Health and Mental I		01.001
		For State Registrar		Certificate c	of Death	Reg. No. UUD	04201
Physicia /Medic		1. Decedent's Name (First, Middle, Last) Charles	Greene		2. Date of Month	. Day Year	3. Time of Death
Examin		4a. Facility Name (If not institution, give		4b. City, Town	n, or Location of Death	4c. County of Dea	th O
		HOWARD County	General	Hospital Colu	mbia	Howar	
Funeral Director		5. Social Security Number 6.3ex	7. Age (In yrs. las	t bishday) If Under 1 Ye  Yrs. Months Day		Birth 9. Bir Day, Year) Co	thplace (State or Foreign ountry)
		213-12-8651 Usual Residence of Decedent	87		June	29, 1918	Maryland
yland		10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
e Ma	ctor	Maryland Prince (	Georges		Laurel		1 ☐ Yes 2 No
or 28	Dire	10e. Street and Number		10f. Zip Cod	9	10g. Citizen of What Co	ountry?
5-UUSD 72 hours after death with the Maryland naturel; or Items 23a or 28e-1 ehow dical Exs. Liner must be notified at	Completed by Funeral Director	Box 213	10.111	10.111.5	20707		S.A.
ter de	nue	11. Marital Status  Na Never Married 2  Married	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Specify Yes of Juban, Mexican, Puerto Rican, etc.	No- 14. Race - Ame Black, White	
urs af	by	3 Widowed 4 Divorced	1 Yes 2 No Korco If Yes, Give Year or Dates: WEE	1 ☐ Yes 2 🕱 1	No Specify:	Specify:	Black
Z1Z15-0U36 d within 72 hours aff glene. sr then "naturel; or tre Medical Exam	ted	15. Decedent's Edu	cation	16a. Decedent's Usual Oc	cupation	16b. Kind of Business	
within 7	nple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use ret	ne during most of working tired)	Edu	cation
filed wi	Cou		5+		Teacher		
and be fill be ott	Be	17. Father's Name (First, Middle, Last)	_		18. Mother's Name (First, Mic	idle, Maiden Sumame)	
Maryland 212 d 2 should be filed within th and Mental Hygiene. ? Is marked other then treumatic event, tra M	ဥ	unknown 19a. Informant's Name/Relationship (Ty		10b Mailing Address (Ctm		Mary (unknown)	7: 0:4:)
and 2 s auth an n 27 ls er treui					eet and Number or Rural Route Nu		ZIP Code)
D - 1 2 2		Mr. Larry Aulton  20a. Method of Disposition		e of Disposition (Name of	nridge Dr. Waldorf, Man	/land 20501 20c. Location - City or	Town, State
Baltimore, Dermit. Pages 1 a Department of Her Importent: If Item Iny injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ P  1 ☐ Donation 5 ☐ Other (Specify)	emoval from State	netery, crematory or other p		D = 141	
Dallimo		21, Signature of Funeral Service License	10 NOVSOL	Bayview Crema 22. Name and Ad		Baitim	ore, MD
Depa Depa Impo		DIWOTHIN	till the subject	Slack	Funeral Home, P.A.		
1		23a. Part1. Ever the dise 1, or simple shock, or 1 t failure. List only or	cations that caus the death.	Do not enter the mode of o	Old Colombia Pike Ellic dying, such as cardiac or respirato	off City, MD 21043	Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	1- 26	Myocardia	1764	200	Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a consequen		ij tolovelio	7	- Lings
Examiner		Sequentially list conditions,	).				
ed sit	Examiner	Sequentially list conditions, if a ry, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a consequen	nee of ye			
oU, be executed sician and burial-transit	xan	that initiated events resulting in death) Last	Due to (or as a consequer	nce of):			
	calE						
DOX sath cert attendin for use	Physiclan/Med	230. Was decedent pregnant	3c. If yes, outcome of pregnanc 1□Live birth 2□Fetal de		nev.	23d. Date of de	livery
that the death	sicle	in the past 12 months? 1  Yes 2 No	4 Pregnant at time of deal			Month	Day Year
at the diby the etache	Phy	9 Unknown			,		
ires that signed t	by	Part II. Other significant conditions con	tributing to death but not resulti	ng in the underlying cause	given in Part I. 23e. L	oid tobacco use contribute to	o the cause of death?  robably 4 Onknown
w requir been si shoutd	eted	Spiration Tremon	Atries Fil	une co	alonge por	Yes 2 No 3 P	obably 4 Monkhown
	Completed	Shock Jepsis	Htria) 1-16	prillation	24a. V	Vas an utopsy erformed? 24b. Were at prior to death?	utopsy findings available completion of cause of
					1 □ Ye	s 2 No 1 Yes	2 <del>2 11</del> 0
OI VIIdI NE Physicien: The la this certificate has	o Be	25. Was case referred to medical examiner?	lospital: 1 Dinpatient 2 DEF	2/0-4	26. Place of Death (Check or Other:		w .
Phys or this oral di	. To	27. Manner of Death	28a. Date of Injury 2	Voulpatient 3L DOA	4 Nursing Home 5 P	lesidence 6 ∐Other (Spe ibe how injury occurred	city)
Attending I r death. ector: After by the funer	atlo	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		Vork? □ Yes 2 □ No		
LIVISION f or Attending after death. Director: After	tiffic	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factory, offic	ce 28f. Locatio	on (Street and Number or Ri Town, State)	ural Route Number,
tel or rs after or el Dir	Certification:		building, etc. (Specify)		Ony of	Town, State)	
Hospi 4 hou Funer ely fill	edical	(Check only 2   Madicel Exami	sician: To the best of my knowledger: On the basis of examination	edge, death occurred at the	a time, date and place, and due to by opinion, death occurred at the tir	the cause(s) and manner as	s stated.
To the Hospitet or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	29b. Signature and title of certifier	and manner stated.		ense number		
Wil To COI	_	The state of the s	1 20-1			29d. Date signed (Mont	200.
11/		20 Name and address of	mpleted square of death (the		6120	100,11	2006
310		F Dob - 10 1	724 / J.LL.	Say (Type, Print)	Pkun Co	lul. van	2006
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatur	" TICKENT	, ruy	914 W	0.011
Registr	_	FEB 1 5 2000	Marine St	Busines	0		

			For State Registrar	State of	Maryland / Dep Ce	artment of I		and Ment		ne) 06	04282
	Physici	20	1. Decedent's Name (First, Middle	le, Last)					ate of Death	Day Year	3. Time of Death
	/Medic		Rosalie	Ann		owski		Feb	ruary	11,2006	1:20 P M
	Examin	er	4a. Facility Name (If not institution			4b. City, Town,			4c. County of Dea	th	
			Johns Hopkins 5. Social Security Number	<del>-</del>	Center 7. Age (In yrs. last birthday,	Baltin		ate of Birth	N/A	Ab-Jan (Olah an Fari)	
	Funeral Director		214-24-8321 Usual Residence of Decedent	1□M 2XTF	76 Yrs.	Months Days		Min. (M	ch 30	ear) C	thplace (State or Foreign ountry) ryland
1	A N		10a. State 10b. County	1	10c. City, Town or L	ocation					10d. Inside City Limits
Was	10 Pa	호	Maryland Bal	timore	Dund	alk					1 ☐ Yes A No
:1215-0036 within 22 hours after death with the Manyland	and Montal Hygiene. Is marked other than "natural", or Items 23e or 28e-f show eumatic event, the Medical Exterding front front by natified at	i Director	10e. Street and Number 7524 Carson Av	enue		10f. Zip Code 212	224		100	. Citizen of What Co USA	ountry?
te ob	tems 2	Funerai	11. Marital Status	Armed Ford	dent Ever in U.S. 13.	Was Decedent of I	Hispanic Original	gin? (Specify Y	es or No-	14. Race - Ame Black, Whi	
036	ral', or l	þ	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced	If Yes Give	<sup>2</sup> XNo	1 ☐ Yes 2 🛣 No				Specify: W	•
Maryland 21215-0036	n "natur Medical	Completed	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-	(Give	dent's Usual Occu wind of work done DO NOT use retire	during most	of working	16	b. Kind of Business	/Industry
212	giene grene	mo;	12 years	College (1-	,	ecretary				Moran Tov	ving
ם י	Mental Hygie Marked other t	Be	17. Father's Name (First, Middle,			_				iden Sumame)	
aryla	Men	၉	Walter Rzepkow				1	a Jurko			
Mar	of other treumatic		19a. Informant's Name/Relations Herman Grubows.			carson A				City or Town, State, .	Zip Code)
altimore,	of Hea		20a. Method of Disposition		20b. Place of Disponentery, cre	osition (Name of	ica)	Fobrus	20	c. Location - City or	Town, State
limor	ment lent: I		1√2 Burial 2 ☐ Cremation `4 ☐ Donation 5 ☐ Other (5	Specify)	HOTA KEG	eemer Cen	etery	15,200	6 Ba	ltimore,	
Bail	Department of Health at Importent: If item 27 is any injury or other treu		21. Signature of Funelial Service	C'-Con	relly?	2. Name and Addre Connelly 7110 Soll	Funera Funera ers Po	al Home oint Ro	Of Di	ındalk,P. <i>R</i> ındalk,Md.	A. 21222
			23a. Part 1. Enter the disease, o shock, or heart failure. List	r complications that ca t only one cause on ea	used the death Do not en	ter the mode of dyi	ing, such as	cardiac or resp	iratory arres		Approximate Interval Between
	nysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Acu	TE RES	PIRAT	DRY	FA)	LURZ		Onset and Death
	xaminer		Composite the link one distance	Le CER	r as a consequence of):  CBC VAST  ir as a consequence of):	CULAR	A	CIDE	NT		
7		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
), v	ial-trar		that initiated events resulting in death) Last		PER TENS or as a consequence of):	*					
8760,	physician and s the burial-transit	dicai		d. YAC	EMAKER						
ox 6	attending p	/Me	IF FEMALE:	23c. If yes, outo	ome of pregnancy					23d. Date of de	liven.
O. BG	the atter	Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown		int at time of death 5	□Ectopic pregnanc □ Other (specify) _	:y			Month	Day Year
<b>G</b> . [4]	ed by the	y Ph	Part II. Other significant conditi	ons contributing to dea	ath but not resulting in the t	anderlying cause gr	ven in Part I.	2	3e. Did toba	co use contribute to	the cause of death?
rds	been signed I	ed by						_	1 🗆 Yes	2 □ No 3 □ P	robably 4 Dunknown
Records, P.O. Box 68760, C. The law requires that the death certificate he eventled	ate has be	Completed			· · · · · · · · · · · · · · · · · · ·				4a. Was an autopsy performe	d death?	utopsy findings available completion of cause of
		O	25. Was case referred to medica	N .			26. Place	of Death (Che		No 1 ☐ Yes	2 <b>2</b> No
₹ <	this certifica	To B	examiner?	Hospital: 1 ☐ In	patient 2 ER/Outpatie	nt 3□ DOA Ott	her			ce 6 □Other (Spe	cify)
Division of	h. After th funeral		27. Mann of Death 1 Natural 5 Pendir	28a. Date of (Month	f Injury 28b. Time of Injury Injury	Wo			escribe how	injury occurred	
Sio	death. c <b>tor</b> : A y the fu	icati	2 Accident investi	not be	of laine. At home form of		Yes 2 N	-	nation /Stra	at and Number of C	use I Courte Number
	after of Directed in Diversity	Certification;	4 Homicide determ	nined 200. Flace of building	of Injury - At home, farm, st g, etc. (Specify)	reet, ractory, onice		ZBI. EG	ity or Town,	et and Number or Ri State)	arar noble Number,
Division of Vita	within 24 hours after death	Medicai C	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the base and manner	pest of my knowledge, deal sis of examination and/or in er stated.	th occurred at the ti evestigation, in my	me, date and opinion, deat	d place, and du th occurred at t	ue to the cau the time, date	se(s) and manner as and place, and due	s stated. a to the cause(s)
Ē	To th comp	Me	29b. Signature and title of certifie	ar -		29c. Licens	se number	70	290	. Date signed (Mont	h, Day, Year)
	^		) avend	y WILL	en MD	$\mathcal{D}$ .	27/5	8		2/13/0	6
	1		30. Name and address of person	who completed cause	of death (Item 23a) (Type	Print)	PI	/ A	1/4-	1-11- X1	0 21222
60	Sta	te	31. Date filed (Month, Day, Year,	) 32. Re	gistrar's Signature	1 BICEL	1 1Cec	0	unc	Kelk 19)	1 -12-22
	Registr		FEB 1 5 2	006	A A Agreed						

Eric R. Garrison Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 06-01069 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 4:40 p. February 10, 2006 Garrison Jr. Renard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Shock Trauma Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 XM 2 ☐ F 33 Yrs. 216-74-5497 Usual Residence of Decedent 09 ΜĎ Director 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits other then "naturel", or items 23s or 28s-f show vent, the Medical Examinar must be notified at Yes 2 No by Funeral Director Catonsville Baltimore MD10e. Street and Number 10g. Citizen of What Country? 21228 U.S.A. 1105 D'Long Road Apt F 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Trucking Company Dispatcher 12th grade na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mental Natalie Jacobs ၉ David Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21228 19a. Informant's Name/Relationship (Type, Print) Heelth Catonsville, Md 1105 D'Long Road Apt F, Shaunte Garrison-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md Metro Crematory 2/16/2006 21. Signature of Fuseral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that baused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Physician /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) attending physicien and for use es the burial-transit or Attending Physician: The law requires that the death certificate be executed Exam resulting in death) Last Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

Yes 2□ No autopsy performed? 2 🗆 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Yos 2 No After thi funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 41001 1 ☐ Yes 2 🛣 No i Director: A investigation SURDECT SHET ST PELICE 2 Accident 2110 106 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) SCL block route found filled in by 4 Homicide within 24 hours efter street STURET RAHIMONE MD 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and maintenance as alabour.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

State Registrar

To the

Mil Tha MI 31. Date filed (Month, Day, Year)

5 2006

32 Registrar's Signature

DHMH 17 Rev 1/2001

one)

29b. Signature and title of certifier

30. Name and address of per

on who completed cause of death (Item 23a) (Type, Print) 111 Penn Street

29c. License number OCME

29d. Date signed (Month, Day, Year)

February 11, 2006

Baltimore, Maryland 21201

			For State Registrar	State of Mary	•	artment of H rtificate of I		-	Z 1111 C	04284		
			1. Decedent's Name (First, Middle, Last)  2. Date of Death						3. Time of Death			
	Physici /Medic		Thelma Belle Gl			February		006 1310 M				
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	r Location of Death		4c. County of			
			Harford Memorial	Hospital			de Grace_			rford		
	Funeral		Social Security Number     6. Se	TM 2MF	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9	. Birthplace (State or Foreign Country)		
	Director		213-20-7918 Usual Residence of Decedent	88	118.			Nov. 22	, 1917	Pennsylvania		
	land		10a. State 10b. County	100	. City, Town or Lo	cation				10d. Inside City Limits		
	Man	ţo	Maryland Harford Edgewood						1 ☐ Yes 2 📉 No			
	or 28	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Country?		
	23a c	al	501 Silverside Road 21040						U.	S. A.		
	ar des	by Funeral	11. Marital Status	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of Hispanic Origin? (Specify f Yes, specify Cuban, Mexican, Puerto Ricar		ecify Yes or No- Rican, etc.)		14. Race - American Indian, Black, White, etc.		
36	s afte	Ϋ́	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced			1□Yes 2X No	Specify:		Specify:			
21215-0036	within 72 hours after death with the Maryland ene. Then "natural", or iteme 23a or 28e-f ehow he Madical Exemples must be multified at	ed	15. Decedent's Ed			dent's Usual Occupation			White 16b. Kind of Business/Industry			
212	on nin 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)  Elementary/Secondary (0-12) College (1-4or 5+)					ing	,			
2	d with	ĕ	12th Grade	College (1-4or 5+)		Timekeep	er		F	Retail		
	d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle, M	faiden Sumame)			
<u>y</u> la	Ment Arker arker atic	ဥ	Arthur Criswell					Minnum				
Maryland	2 sh and is m	1 19	19a. Informant's Name/Relationship (7		19b. Mailir	ng Address (Street	and Number or Rui	al Route Number,	City or Town, Sta	ate, Zip Code)		
e)	of Health and Item 27 is		Sandra Hann (Daug		501 S Ob. Place of Dispo		e Rd., Ed		Maryland 20c. Location - Ci			
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hydione. Depertment of Health and Mental Hydione. Depertment of Health and Mental Hydione. Environment of Health and Mental Hydione. Environment of the resulting and the page.  PAGE.		1 ☐ Burial 2 ☐ Cremation 3 🛱	Removal from State	cemetery, cren	natory or other plac	(e)	14/	Kelly To	wnship,		
를	nit. Partme	. 3	4 □Donation 5 □Other (Specify  21. Signature of Eureral Service Licen:			1 Cemete:			Pennsylv	vania Home of Bel Ai		
Ba	Departiment of the popular in popular ir pop		Malle	11						, Md. 21014		
ľ			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between									
	Physician		Immediate Cause (Final disease or condition		mic S	TROKE				Onset and Death 30 MINUTES		
1	/Medical Examiner		resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to inhimediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C. Due to (or as a consequence of):							35 141100723		
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	ntifice ng phy as th		IS SELVALE.									
ž S	seth certil attanding for use a	an/	IF FEMALE:  23b. Was decedent pregnant  1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy						23d. Date of delivery			
P.O. Box	e dee the at hed fo	Physician/M	in the past 12 months? 1 □ Yes 2 2 No 9 □ Unknown			Month	Month Day Year					
<u>ď</u>	res that the deeth certigned by the attendin be deteched for use	P <sub>r</sub>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use co		antithute to the cause of death?		
ds,	signe d be	d by	CORONARY HEART DISEASE						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷			
Š	w require been sig should b	e Completed	HEART FAILURE							24b. Were autopsy findings available		
Be	he lev e has age 2		autopsy						prior to completion of cause of death?			
ta	an: T tificat tor, pa		25. Was case referred to medical				26 Place of Deal	1 ☐ Yes 2		Yes 2□No		
₹	nysici iis cer direc	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 6 Inpatient	2 ER/Outpatien	nt 3 DOA Oth		ome 5 Reside	-	(Specify)		
Division of Vital Records,	ng Pt fter th ineral	Certification; 1	27. Manner of Death 1 Natural 5 Pending					28d. Describe how injury occurred				
Sio	tendi leath. Ior: A the fu		2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No								
<u>≥</u>	or At aftar o Direct in by	artifi	4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)					
_	To the Hospitel or Attending Physician: The lew requires that the deeth certif within 24 hours eiter death.  Ye the Funeral Director: Aller this certificate has been signed by the attending completally filled in by the funeral director, page 2 should be deteched for use a	aj Ce	29a. Certifier 1 Certifying Ph	ysician: To the best of my	y knowledge dawl	h secured at the fir	ine, date and nison	and due to the ex	use(s) and nive	or as statud		
	n 24 h	edicai	(Check only 2 Medical Examone)	iner: On the basis of exa- and manner stated.	mination and/or in	vestigation, in my o	pinion, death occur	red at the time, da	ite and place, and	d due to the cause(s)		
	withir To th comp	ž	29b. Signature and title of certifier  29c. License number  29d. Date signer						d. Date signed (	Month, Day, Year)		
			(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address in person who completed cause of death (Item 23a) (Type, Print)  DR. ADURVA DESAI 501S. UNION AVE HAVRE de GRACE, MO 21078  31. Date filed (Month, Day, Year)  FEB 1 5 2006							13,2006		
	12		30. Name and address person who d	completed cause of death	(Item 23a) (Type,	Print) //	10	. /	2			
	0		DR. ADURVA DES 31. Date filed (Month, Day, Year)	A1 5015.1	UNION A	VE MAVI	rede GR	race, MC	) 2107	18		
	Sta Registi			2006 2006	o St. A	gaste)						

GlASS MYER, The IMA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Amend I Decedent's Name (First, Mi Certificate of Death Reg. No. UU6 Per FH G852 tem 2. Date of Death 3. Time of Death Day **Physician** 5:15 pm JULIA FEB. GOJIN 11,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MANORCARE BALTIMORE ROSSVILLE BALTIMORE 8. Date of Birth (Month, Day Year) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 UKRAINE **Funeral** 1 □ M 2X Months Days Hours Min 81 212-32-1089 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "natural", or items 23s or 28s-f show the Madical Examinar must be notified at 10d. Inside City Limits 1 ☐ Yes 2 X No Director MD. BALTIMORE BALTIMORE 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3709 INA AVENUE 21206 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 20 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ Yo Specify: Specify: WHITE <u>ک</u> 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 DOMESTIC MD. NAT'l BANK 17. Father's Name (First, Middle, Last)
John
UNKNOWN
MA 18. Mother's Name (First, Middle, Maiden Surname) Be should be I MALEC **UNKNOWN** Sophia ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) , 1 end 2 s of Heelth at if itsm 27 i MICHAEL GOJIN/ HUSBAND 3709 INA AVENUE BALTIMORE MD. Baltimore, 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Important: If sny Injury or sny Injury or snot. ST. MICHAEL'S UKR. CEM. 2/14/06 BALTIMORE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundamental Service Licensee 22. Name and Address of Facility ZEILER EASTERN A 1901<sup>Y</sup> ER INC. FUNERAL HOME AVENUE, BALTIMORE, MD 21231 23a: Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** YPOK1A /Medical Due to (or as a consequence of) Examiner ENC Erita Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine as the burial-transit be executed SWA( and resulting in death) Last Due to (or as a consequence of) Box 68760. physicien Physician/Medical certificate ed by the ettending detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months2 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) Ö 9 Unknown 9 Unknown ے should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۵ HEARS Lon GESTIVE 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cete has I 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 No of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Division 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No or Attend after death Director: 2 Accident 6 Could not be determined 3 🗍 Suicide 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital within 24 hours a To the Funaral D 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Th 3 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHITE DENNIS . H' ODIE 1 th LAD ELITHA BAUTO MO 212-37 9106 000 31. Date filed (Month, Day, Year) 32. Registrar's Signature State fresh Registrar

ORIGINAL

# **VOID**

# **CERTIFICATE** #

2006-04286

# SEE

**CERTIFICATE** #

2006-15477

		For State Registrar	State of M	laryland		artment o			ental Hy	giene	)6	0428	7
Physici	an	1. Decedent's Name (First,							2. Date of De	Day	Year	3. Tîme of Dea	
/Medic Examin	al	EDWARD  4a. Facility Name (If not inst	JEFFERSON itution, give street and number	HART	Jr		wn, or Location	on of Death	Februa	1.4	2006 ty of Death	7	AM
Examili	er S.	Maryland	1 General	Hoss	tal	73à	Himar	P Ci	ty		1/6	7	
Funeral Director		5. Social Security Number 214 40 789	V	ge (In <i>yrs. l</i> as 65	t birthday, Yrs.	Months D	ear If Und	ler 24 Hrs. s Min.	8. Dele of Bir (Month, Da MARCH	th 14,1940	9. Birth	place (State or Fo. <b>KYLAND</b>	reign
D D		Usual Residence of Deceder 10a. State 10b. C		10c. City,	Town or L	ocation						10d. Inside City Li	îmits
Maryle -f eho	tor		TIMORE	MID		RIVE	₹					1 ☐ Yes 2X	_
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Department of Health and Menial Hygiene. This properties 71 is marked other then "natural; or items 23e or 28e-1 show eny injury or other traumatic event. It is Marical Examinar must be notified at once.	Funeral Director	10e. Street and Number 9730 MAT	ZON ROAD			10f. Zip Cd 21	ode 220			10g. Citizen o		ntry?	
er deal	uner	11. Marital Status 1 ☐ Never Married 2 ☐	12. Was Deceden Armed Forces Married 1X Yes 2	?	13.	Was Deceden If Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Specan, Puerto	cify Yes or No Rican, etc.)	)- 14. R	ace - Ameri ack, White,		
5-0036 72 hours after natural; or to	þ	3 Widowed 4 Div	If Yes Give	VIETN	AM	1 ☐ Yes 2 ☐	XNo Spec	ity:		Spec	ify:	WHITE	
15-(1) 15	Completed	(Specify only	cedent's Education highest grade completed)		(Give	dent's Usual C kind of work of DO NOT use i	ione durina m	ost of worki	ng	16b. Kind of	Business/In	dustry	
d 2121 filed within Hygiene. ther then	Com	Elementary/Secondary (0	0	5+)		INDUS				CONT		ING	
ore, Maryland 212: ges 1 and 2 should be filed within t of Health and Mental Hygiene. If it flem 27 is marked other than or other traumatic event. Last	To Be	17. Father's Name (First, M EDWARD J.							(First, Middle ETH A	, Maiden Suma			
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ore, Northwalth litem 27		20a. Method of Disposition		1	ce of Disp	osition (Name ematory or othe	of	-	ate	20c. Location	•		
Baltimore, permit. Pages 1 a Department of Hes Important: If them eny injury or othe once.		4 ☐ Donation 5 ☐ Oti		MET	RO C	REMAT	ORY	2/14		BALTI			- 250
Balt permit. Departr importu		21. Signature of Fuceral Se	rvice Licensee		2	2. Name and A		CV	-	OSEDAL BALTIM		NERAL H MD 212	
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To the within To the compile	Me	29b. Signature and title of o	1/ / 1 /	D6.			icense numb			29d. Date sign		-	
		30 Name and address of o	erson who completed cause of		23a) (Tuno		295	66		, y-1	0.0	6	
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Sta Regist		31. Date filed (Month, Day, FEB 1 5		trar's Signatu	ге								

			For State Registrar	State of Marylar		ent of Health and late of Death	Mental Hygie	ZUUD	04288	
	Physici	an	Decedent's Name (First, Middle, Last)	\4			2. Date of Death Month	Day Year	3. Time of Death	
	/Medic Examin		4a. Facility Name (If not institution, give s		4b. Ci	BOL Hood	re	4c. County of Death	1.up.	
	Funeral Director		5. Social Security Number 6. Sex 230 -28-0806 12 Usual Residence of Decedent	M 2□F	/ If Und Month	der 1 Year If Under 24 Hrs is Days Hours Min.	8. Date of Birth	29 Vi	place (State or Foreign intry)	
	Maryland a-f show	Funeral Director	10a. State 10b. County	10c. Ci	ty, Town or Location  Bodhin	nore			10d. Inside City Limits 1 Yes 2 □ No	
	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyghene. Item 27 Is marked other than "natural; or Itema 23a or 28a-f show other traumatic event, The Medical Examination and the rollified at		10e. Street and Number 2555 Garrey	4 Aveni	10f.	Zip Code 21218		Citizen of What Cou	intry?	
396		by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		cedent of Hispanic Origin? (Specify Cuban, Mexican, Puerl	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White		
21215-0036		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Sedormary (0-12)	cation a completed) College (1-4or 5+)	16a. Decedent's U (Give kind of life. DO NOT	work done during most of wo	rking 16	b. Kind of Business/li	ndustry	
		Be Col	17. Father's Name (First, Middle, Last)		Compr	18. Mother's Nat	me (First, Middle, Ma	OGTOWS iden Sumame)	#OINT	
Maryland		To	John Hine  19a. Informant's Name/Relationship (Ty)	S Print)	10h Mailing Addre	ess (Street and Number or Ri	e Mae	. HINES		
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Baltimore,	ages 1 nt of He t: If iten / or oth		20a. Method of Disposition  1 Burial 2 □ Cremation 3 □ R	emoval from State	Place of Disposition (Accemetery, crematory of	lame of r other place)	2/18/06 V	c. Location - City or T		
altin	permit. Pages Department of h Important: If ite any injury or of		'4 □Donation 5 □Other (Specify)  21. Signature of Funeral Service License		CLOONIAB	and Address of Facility	PANE FE IA	eg 3011/ eg al Se	e Virginia	
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Vital Records,			24a. Was an autopsy						24b. Were autopsy findings available prior to completion of cause of	
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o uo		Certification:	27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)  28b. Time of lnjury at Work?  M 1 Yes 2 No			28d. Describe how injury occurred			
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	To the within To the comple	Med	29b. Signature and title of certifier		2	29c. License number		Date signed (Month,	* * * * * * * * * * * * * * * * * * * *	
	Q		30. Name and address of person who co	moleted cause of death (Iter	m 23a) (Type Print)	7-2792	-	219/0	<b>5</b>	
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	-		1 - State Amend Items#12	2&17 per 1	FH G852 @	partment of H	Death		Reg. No.	06	04289
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	uh with the 23a or 28 ust be no	ai Dire	10e. Street and Number 1703 Pinewood Driv	<i>7</i> e		10f. Zip Code 212	22		10g. Citizen o USA	f What Count	try?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at ODGs.	l by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☒ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? XXYes 2 If Yes, Give Year or Dates:	ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		ace - America lack, White, e sify: Whi	etc.
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Z	nd 2 st alth and 27 le r r traur		Edith Hutchinson	wife		Pinewood				-	C0 <b>06</b> )
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Fune Direc				C++ +C-	e (In yrs. last bii 85	Yrs.		Days	Hours	Min.	8. Date of Bir (Month, Da Aug. 1	y, Year)	O Ma	nplace (State or Foreign untry) aryland
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To the Hospital or Attending Physician: The law within 24 hours efter death.  To the Funeral Director: After this certificate has	e funeral di	ation: To	1 Yes 2 No  27. Manner of De ith  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injui (Month, Da)		utpatien Time of Injury		Bc. Injury Work	4 🔲 140	2	ne 5 ☐ Resi 28d. Describe	-		city)NVOSP į
al or Atter s efter dea	ad in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		ury - At home, f	arm, str	eet, factory	, office		2		Street and N wn, State)	umber or Ru	ural Route Number,
e Hospit 24 hour e Funera	letely till.	edicai (	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Exa	nysician: To the best oniner: On the basis of and manner sta	l exam≀nation a	e, death	occurred evestigation,	at the tim	e, date an pinion, dea	d place, a	and due to the ed at the time,	cause(s) and date and pla	d manner as ace, and due	stated. to the cause(s)
To th within To th	COMP	Me	29b. Signature and title of certifier	l					number				-	h, Day, Year)
17			Heran	v no			]	)58	330	3		FEBR	wary	13 200%
0			30. Name and address of person who		leath (Item 23a)	(Type,	Print)	wles	St	Ba	nm	y no	2120	13 2006
Re	Sta gistr		31. Date filed (Month, Day, Year) FEB 1 5 2	100	ar's Signature	A STATE OF THE PARTY OF THE PAR	رهاه							/

10:58 pm

Elizabeth

			For State Registrar	State of Ma	aryland		artment of H <i>tificate of I</i>			giene 0 0	6 04291
10	4 40 A 19		Decedent's Name (First, Middle, La	st)			-		2. Date of Dea Month	ath	3. Time of Death
	Physicia /Medic		Bernard Hagar	n, Jr.					Februar		
	Examin		4a. Facility Name (If not institution, giv				_	Location of Death		4c. County of (	
	\$100 m	No.	3 Southerly Cour 5. Social Security Number 6. S		. (In un la	ist birthday)	Towson If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Baltimo	Per Birthplace (State or Foreign
K	Funeral Director		219-07-2307	M 2□F	85		Months Days	Hours Min.	Sept. 1	4 <sup>Year)</sup> 1920	Maryland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City	Town or Lo	cation				10d. Inside City Limits
	Mary -1 eh	ţō	Md. Balt	imore			Towso	п			1 ☐ Yes 2X No
	n the	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wha	it Country?
	23a c		3 Southerly Co	urt Apt.	607		2	1286		US	SA .
	ems erms	Funerai	11. Marital Status	12. Was Decedent E Armed Forces?		3. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-	14. Race - A	American Indian, White, etc.
36	s afte	<b>by</b> Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🔀 Divorced	1 DXYes 2 □ N If Yes, Give	₁₀ WWII	1 .	1 ☐ Yes 2 🕱 No	Specify:		Specify:	White
21215-003	72 hours after death with the Maryland natural; or terms 23a or 28a-f ehow itsal Ezaninas munt te mutified at		15. Decedent's E	Year or Dates:	mmTT	1	dent's Usual Occup	ation		16b. Kind of Busin	
2	- 3	piet	(Specify only highest gra Elementary/Secondary (0-12)			(Give	kind of work done of DO NOT use retired	during most of work	ring	Baltimor	
212	filed within Hygiene. other then "	Completed	Elementary/Secondary (0-12)	5+	7		Teac	her		School 9	Gystem
nd	be filed within 72 hours after death with the Marylan tal Hygiene.  de thyriten "natural", or Itema 23a or 28a-1 show or other then "natural", or Itema 23a or 28a-1 show event, I'm Madisal Eraininar munt be indiffed at	Be (	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	e (First, Middle,	Maiden Sumame)	
<u> </u>	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Mi	ပ္		Hagan, Sr.						: Kammerme	
Maryland			19a. Informant's Name/Relationship (				therly Ct			or, City or Town, Sta	
	1 and Health Iem 27 other tr		Ms. Dolores Haga 20a. Method of Disposition	ulgisrei	20b. Pl		sition (Name of matory or other place		Towson, Date	Maryland 20c. Location - Cit	
<u>o</u> E	Pages nent of int: If it		1 🗷 Burial 2 □ Cremation 3 □ 4 □ Donation 3 □ Other (Special		1		natory or other plac Redeemen		/14/06	Baltimore	e, Maryland
altimore,	permit. Page Depertment of Important: If eny injury or once.		21. Signature of Funeral Service Lice	Fr)	, 100 0		. Name and Addre		11700		rk Road
Ö	9 9 1 9		hers C	duy		Ru	ick Towso	n Funeral	Home	Towson,	MD 21204
1444 jih			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each lir	the death	. Do not ent	er the mode of dyin	ng, such as cardiac	or respiratory ar	rest,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	_a	a cu	te 1	KI .				Minutes
	/Medical Examiner		resulting in death)	Due to (or as	a eonsequ	ence of):	1+	Q.			4.
36.		P	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	ence of):X	Trery	Desease			ran
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		· ·	0	0				9
oʻ	exectan and and rial-tra		resulting in death) Last	Due to (or as	a consequ	ence of):					
38760,	icate be executed physician and s the burial-transit	dicai	•	d							
•		യ	IF FEMALE:	22a If was sutsame	01.00000						
Вох	attend for us	ian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal	death 3	Ectopic pregnancy Other (specify)	/		23d. Date of Month	
<u>Р</u> О	thet the de ned by the a detached t	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	(ime or de	<b>J</b>					
	The law requires that the death certif ate hes been signed by the attending page 2 should be detached for use an	by Pt	Part II. Other significant conditions	contributing to death b	ut not resu	llting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
rds	w require been sig should b		1/A/CVF	<u> </u>					1 🗆 1	res 2200 31	Probably 4 Unknown
Division of Vital Records,	e law re hes bei je 2 sho	Completed							24a. Was autop	an 24b. We	re autopsy findings available or to completion of cause of
œ —	ding Physicien: The I h. After this certificate he funeral director, page	Com								rmied? dea	th? I Yes 2 □ No
/ita	cien: ertific ector,	Be	25. Was case referred to medical examiner?					26. Place of Dea	th (Check only o	nhe)	
of	Physic this c	. To	1 Yes 2 Mo	Hospital: 1 Inpatie		ER/Outpatier 28b. Time o		4   Nuising n		dence 6 Other	(Specify)
no	ding h. After funer	tion	Natural 5 ☐ Pending	28a. Date of Inju (Month, Day	y Year)	Injury	Wor	rk? Yes 2 No	200. Describe r	now injury occurred	
/isi	Atten r deat ector: by the	fica	3 Suicide 6 Could not I	28e. Place of Inju	ury - At ho	me, farm, st	reet, factory, office				or Rural Route Number,
ă	s efte	Certification:	4  Homicide determined	building, etc	c. (Specify	')			City or Tov	wn, State)	
	To the Hospital or Attending Physicien: within 24 hours effer death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Medicai	29a. Certifier Certifying P	hysician: To the best miner: On the basis of and manner sta	f examinat	wledge, deat ion and/or in	h occurred at the til vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)
	ro the vithin of the comple	Me	29b. Signature and title of certifier	A marinor sta			29c. Licens	se number		29d. Date signed (i	Month, Dey, Year)
	, \		Varietee !	All To	M		1)	-809		2/10/	106
11	114		30. Name and address of person who	completed cause of d	leath (Item	23a) (Type,	Print)	7 /	0 h	D.	. 10
1			31. Date filed (Month, Day, Year)	JrMs/ GOO	d Xa	marita	uttagg. S	601 Lock	Care Bl	of Betti	more, Mangland
	Sta Regist		FEB 1 5 200	16 Harris	ar's Signa	A second	les "			/	21139

			For State Registrar	State	of Marylan		irtment of H tificate of L		Mental Hygie	ene .2.00	5	14292
			Decedent's Name (First, Middle	, Last)			· · · ·		2. Date of Death			3. Time of Death
	Physicia	_	A. Frank Ho	lston J	r				February	Day 10, 2	Year 2006	5:38 P M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Death		4c. County		J.30 1
	LAGIIIII	GI	Spa Creek Cen	ter	·		Annapol	ie		Ann	e Aru	ındel
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		9. Birthp	lace (State or Foreign
	Director		217-24-3558	1 <b>⊠</b> M 2□F	77	Yrs.	Months Days	Hours Min.	(Month, Day, Y	1928	Coun Ral	timore, MD.
	-		Usual Residence of Decedent						1100. 20,	1,720		OZINOT C 9 T ID .
	ylan		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mar a-f	io	MD Anne	Arundel	Anı	napolis	3					1 ☐ Yes 2 ☑ No
	r 28	Director	10e. Street and Number	14 41 41			10f. Zip Code		100	. Citizen of V	What Coun	try?
	73a c		2 B1 Spa Creek	Landing				21403		United	Stat	ces
	deat	Funerai	11. Marital Status		cedent Ever in U	.S. 13. V	Vas Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sr	pecify Yes or No-		e - Ameno	
٥	after or Ita		1 ☐ Never Married 2 ☑ Marri	ed 1 Yes	2 <b>№</b> No		-		nican, etc.)	250.0	k, White,	
2	ral',	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or			I□Yes 2√√ No	Specify:		Specify	/:	White
9500-G1Z1Z	72 h	Completed	15. Decedent (Specify only highes		f)	16a. Deced	lent's Usual Occupa	ation during most of wor	kina 16	Bb. Kind of Bu	usiness/Ind	dustry
7	thin 9.	npie	Elementary/Secondary (0-12)	- T	(1-4or 5+)	life. L	DO NOT use retired	()				
	od wi	Col		5-	<u> </u>	Profe	essor			Colleg		
2	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "natural", or Itams 23a or 28a-f show event, the Medical Examinating the notified at	Be (	17. Father's Name (First, Middle,	Last)				18. Mother's Nam	ne (First, Middle, Ma	aiden Suman	10)	II.
<u>a</u>	as 1 and 2 should be filed within 72 hours after death with the Marylan of Heath and Mental Hygiene. I itam 27 is marked other then "naturel", or Itams 23a or 28a-f show rether traumatic event, the Medical Exercities must be notified at	Tol	A. Frank Hols	ton, Sr.				Sara A	lice Jett			
Maryland	2 sho and I Is me		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address (Street	and Number or Ru	ral Route Number, (	City or Town,	State, Zip	Code)
	and 2 salth n 27 l		Marianne Hols	ton/wife		2B1 9	Spa Creek	Landing	Annapoli	s, Mar	yland	1 21403
Baitimore,	of He of He fitam		20a. Method of Disposition	• = •		Place of Dispo	sition (Name of natory or other place	ee)	Date 20	c. Location -	City or To	wn, State
Ĕ	Pagas nent of I int: If its iry or o		1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (Si		n State	-	Valley M		15/06 T	imoniu	ım. Ma	aryland
	permit. Pagas Department of Important: If it any injury or o		21. Signar re of Funeral Service						ck Towson			
ñ	Per Per Per Per Per Per Per Per Per Per		MILLER	Ster	hen Cos	ter 1	150 Vork	Road To	wson, Mar	vjand Luier	21 20/	ine, Inc.
			23a. Part1. Enter the disease, or	complications that	t caused the deat					_	2120-	Approximate
			shock, or heart failure. List Immediate Cause (Final	only one cause on		~ A	- 11- 00	,				Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	a	avalia		ry/bucc					
	Examiner			Due to	o (or as a conseq	(uence of):	1					13
		e	Sequentially list conditions, if any, leading to immediate	b. Due to	o (or as a consec	mence of:		_			_	
	ad	ol n	Cause (Disease or injury		0, 00 0 00,000	1401100 01):						
_	xacul and I-trar	Examin	that initiated events resulting in death) Last	c. Due to	o (or as a consec	uence of):					-	
8760	icate ba exacutad physician and s the burial-transit	aiE				, , .						
8	cate phys	dicai		d.								
9 ×	artiffi ding	0	IF FEMALE:	220 Huge o	outcome of pregna	ana.						
Вох	death cartifi e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Feta	al death 3	Ectopic pregnancy	,			te of delive onth	Day Year
O	the a	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unk	gnant at time of c known	ieath 5∟	Other (specify)					
<u>ď</u>	The law requires that the death cartificate has been signed by the attending page 2 should be detached for use as	Ph	Part II. Other significant condition	AR contribution to	death but not so	tultion in the u	ndorhing gause ga	on in Part I	23e Did toba	occo use cont	ribute to th	ne cause of death?
Ś	res tha iignad ba det	by	Car Wa 14	Postino	A IZ	Loce		on in raici.		2 🗆 No	3 Prob	
20	w requir been si should	ted	G003110 10	CEFINO	4 [	0000			1 1 1 1 1 1 1 1 1	2 110	3   100	ably * Olikliowil
Records,	e law l has b	Completed							24a. Was an autopsy	24b.	Were auto	psy findings available appletion of cause of
<u> </u>		TO.							performe 1 □ Yes 24	od?	death? 1 🗌 Yes	2□ No
Vital	Physician: Th r this certificate ral director, pag	Be (	25. Was case referred to medical examiner?				- 8	26. Place of Dea	th (Check only one,			
>	di is	2	1 ☐ Yes 2 No	Hospital: 1	☐Inpatient 2☐	ER/Outpatier	nt 3 DOA Oth	er: 4 Mursing H	ome 5 Residen	ce 6 Oth	er (Specify	v)
Division of	ding Ph h. After th funeral		27. Manner of Death		e of Injury onth, Day Year)	28b. Time of Injury	28c. Injur Wor	y at	28d. Describe how			
0	Attending or death.  actor: After by the funer	Certification:	Natural 5 Pendin Pendin Pendin	9	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		Yes 2 □ No				
<u>X</u>	or Attendated after death Diractor: in by the	tific	3 Suicide 6 Could in determined	inad 208. Fla	ce of Injury - At h	iome, farm, str	eet, factory, office		28f. Location (Stree		er or Rura	l Route Number,
	al or A	Cert	· Indinisies	Dui	iding, oic. (Opeci	· <b>y</b> /			Chy or Youn,	Ciaio)		- 1
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	iai	29a. Certifier 1 Certifyin	g Physicien: To t	he best of my kno	owledge, deat	h occurred at the tin	ne, date and place	, and due to the cau	ise(s) and ma	anner as si	ated.
	ne Ho n 24 na Fu	ledical	(Check only 2 Medical one)	Exeminer: On the	basis of examina anner stated.	ation and/or in	vestigation, in my o	pinion, death occu	rred at the time, dat	e and place,	and due to	me cause(s)
	withii To th	ž	29b. Signature and title of certifie				29c. Licens	e number	29	d. Date signe	d (Month,	Day, Year)
)			1				172	5772	8	7-12	3-1	
	207		30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Type.	Print)			~ \~		<b>O</b>
C	1		Aditio Oh	mora in			Zedacl	1) Supt	231 Anr	VIMI	5 m	D.Z1401
	Sta	ate	31. Date filed (Month, Day, Year)	A 32.	Registrar's Sign	ature	- Whi	7	7 11 11	The second	- 1.1	
8	Regist		FEB 1 5 200	6	Registrar's Sign	April 1 St.	e d'					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 0549 A **Physician** 2006 FEBRUARY Claire R. Hansman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore <u>Union Memorial Hospital</u> Baltimore City If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 8. Date of Birth (Month, Day, Year) 1 ☐ M 212 F Director 212-26-1085 76 12/27/1929 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location is 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene. It am 27 is marked other than "natural", or itema 23a or 28a-f ahow other traumatic avent, the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 522 Eckhart Drive U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Shelton Sawver Madeline Steinkraus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Peges 1 and 2 sk Department of Health and Important: If Itam 27 is m any injury or other traum once. Laurie Cucchiella (daughter) 522 Eckhart Drive - Joppa, Marylsand 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St.Paul's Luth. Cem. 02/09/2006 Kingsville Maryland 21. Signature of Funeral Service Licerisee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 60 aa 11750 Belair Road - Kingsville, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between MYLODYSPLAGTEC onset and Death GYN DROME Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Completed by Physician/Medical use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 menths? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OTABETES MEULT YUS TRANSFUSIONAL TRON OVERUAD 23e. Did tobacco use contribute to the cause of death? Records, 8 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 hes Vital Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No ၀ 1 Unpatient 2 ER/Outpatient 3 DOA filled in y the funeral 27. Manner of Death 1 ☑Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation efter death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e a Funaral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the date (s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Fund

completely f (Check only one) that a 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed ause of death (Item 23a) (Type, Print)
NESELTY LE MD 5.351 200 E. 33RA ST. BRUT. MD. 212 18 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 5 2006 Registrar

		1 - For State Registrar	State of M	•	partment o <i>ertificate</i> (		d Mental Hyg R	piene leg. No. 006	04294
Dhusisi		1. Decedent's Name (First, Middle, Las	t)				2. Date of Dea Month	th Day Year	3. Time of Death
Physici /Medio		Doris C. Her		<del></del>			Feb.	14,2006	8:00ам
Examir	er	4a. Facility Name (If not institution, give				vn, or Location of D	eath	4c. County of Deat	h
		Carroll Luth				tminster ear   If Under 24	His Day of Bart	Carro	
Funeral Director		5. Social Security Number 6. Social Security Number 1	x □M 2[ <b>X</b> F /.A	ge (In yrs. last birthd 93 Yrs	Months D		Hrs. 8. Date of Birth Min. (Month, Day	129ar 1913 Co	hplace (State or Foreign nuntry)
		Usual Residence of Decedent						Mar	yland
yland		10a. State 10b. County		10c. City, Town o	Location				10d. Inside City Limits
e-fsl	ctor	Md. Baltimor	е	Upperc	0				1 ☐ Yes 2 ☐ No
38 or 28	Il Director	10e. Street and Number 17434 F	alls Rd.		10f. Zip Co	21155	1	0g. Citizen of What Co	
should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or Items 23e or 28e-f show imatic event, the Medical Event real feets life of all	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deceden Armed Forces 1 Tyes 2 W If Yes, Give Year or Dates:	No	3. Was Decedent If Yes, specify		? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ame Black, White Specify:	
hin 72 ho 9. 9n "natur Medicul	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	ucation de completed) College (1-4or	(G	cedent's Usual O ive kind of work d e. DO NOT use re	ccupation one during most of atired)	working	16b. Kind of Business/	Industry
od wit	Corr	12		1	pusewife			Homemak	er
m - 0 5	Be (	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle,	Maiden Sumame)	
ould be 1 Mental I arked of	ပ	James B. Wheel					ella Sixx		
2 sh and Is m		19a. Informant's Name/Relationship (7			-			r, City or Town, State, 2	Zip Code)
l and lealth om 27 her t		Jean Hare	vaugnter		position (Name of		perco, Md.	21155 20c. Location - City or	T Chad-
Pages nent of h ant: If ite		1 Burial 2 Cremation 3  4 Donation 5 Other (Specify		nomoton:	rematory or other	place)	4	Hamostead.	
permit. Pages 1 and 2 should be Department of Health, and Menta Important: If item 27 Is marked any injury or other treumatic evonce.		21. Signature of Juneral Service Licen	// //_/	2	Folkhand	ddress of Facility	Chanal I		
/Medical Examiner that the private physician and private the private transit	dical Examiner	23a. Part 1. Enter the disease, or composition shock, or heart failure. List only disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or a b. Due to (Ur a. c.	s a consequence of):	viter	y Alex	Line Comments	esi,	Approximate Interval Between Onset and Death
death certi e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal death	3 □Ectopic pregn 5 □ Other (specif			23d. Date of deli Month	ivery Day Year
The law requires that the tite has been signed by thogge 2 should be detache	by	Part II. Other significant conditions of	entributing to death	but not resulting in th	underlying caus	e given in Part I.		bacco use contribute to es 2 □ No 3 □ Pr	1/
	Completed	Herewid anative	Rent	Last.	140		24a. Was a autops perfori 1 \( \text{Yes} \)	sy prior to d	topsy findings available completion of cause of
rysicien: Th nis certificate I director, pag	Be (	25. Was case referred to medical examiner?		1			Death (Check only or	ne)	
ling Phys n. After this funeral di	tlon; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation	Hospital: 1 ☐ Inpat 28a. Date of Inj (Month, D	ient 2 ☐ ER/Outpa ury ay Year) 28b. Tim Inju		Other: 4 Nursir Injury at Work? 1 Yes 2 No	-	ence 6 Other (Spec ow injury occurred	cify)
al or Attenc after death I Director: d in by the	Certification;	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	280. Place of Ir	njury - At home, farm, etc. (Specify)			28f. Location (Si City or Town	treet and Number or Ru n, State)	ıral Route Number,
To the Hospital within 24 hours a To the Funeral Completely filled	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the bes iner: On the basis and manner s	of examination and/o	eath occurred at the investigation, in	ne time, date and p my opinion, death o	lace, and due to the coccurred at the time, d	ause(s) and manner as ate and place, and due	stated. to the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier	70		29c. Li	cense number		9d. Date signed (Month	Day, Year)
3		30. Name and address of person who	completed cause of	death (Item 23a) (Ty	De, Print)	21 V	UE STIM	1257EZ	7
		31. Date filed (Month, Day, Year)	12. Bonin	trar's Signature	88 LE	Dell	1-1ct-	x 115	/
Sta <b>Reg</b> isti	- 80	FEB 1 5 200		At A					

	,	For	State of Maryland / Department of Health and		-ZUUb	04295
Physicia	'n	1. Decedent's Name (First, Middle, La	#19a&20c Per FH C852 tiligate 65 Death	2. Date of Death	Day Year	3. Time of Death
/Medica Examine	al	4a. Facility Name (If not institution, gire	e street and number)  4b. City, Town, or Location of Deal	tebruaru	12, 2006 4c. County of Death	12:55 AM
Funeral		5. Social Security Number 6.5			9. Birthe	lace (State or Foreign
Director		219-26-8368 Usual Residence of Decedent	M 200F 65 Yrs. Months Days Hours Min.	May 19	1940 Vir	ginia
ehow	_	10a. State 10b. County	10c. City, Town or Location		1	Od. tnside City Limits
ith the M or 28a-f	Director	10e. Street and Number	Haltimore Apti 101. Zip Code	10	g. Citizen of What Cour	1 Myes 2 □ No
death wil	Funeral D	2902 Wyn	ham Rd. A 21216	Specify Yes or No.	14. Race - Americ	an Indian
d 21215-0036 Iffed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Items 23s or 28s-1 show out, tra Madical Everal at most be redified at	by Fun	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? If Yes, specify Cuban, Mexican, Puer 1 ☐ Yes, Give 1 ☐ Yes 2 ☑ No Specify:	to Rican, etc.)	Black, White,	
21215-0036 ad within 72 hours af glene. or than "natural; or than "natural; or than "natural."		15. Decedent's E (Specify only highest gr	de completed) (Give kind of work done during most of wo	rkina 1	6b. Kind of Business/Inc	dustry
of the within I Hygiene.	Completed	Elementary/Secondary (0-12)	College (1-40r5+) Teachers Aid		School	Sustem
Vland when the fitter when the state of the	Be	17. Father's Name (First, Middle, Last		me (First, Middle, M	1	i
and and and and and and and and and and	2	19a. tnformant's Nam Pelationship (MS. Den se	Type, Print) (Laughter) 19b. Mailing Address (Street and Number or Ri	ural Route Number,		970n code)
ore, M	1	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)	Balty Date 2	MORE Md	
Pa Pantine ury	ř	1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci.	Western Star 21",	1/2006 4	Baltimore	He Md.
Baltim permit. Pa Departmen Importent: any Injury		21. Signature of Funeral Service Lice		uneral to	tome, P.A.	1
et.		23a. Pany Enter the disease, or com shook, or heart failure. List only Immediate Cause (Final	plications that caused the death. Do not enter the mode of dying, such as cardial one cause on each line.	c or respiratory arre	st,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		disease or condition resulting in death)	a. Slpsis Syndrmu.  Due to (or as a consequence of):			
× 2%	Je	Sequentially list conditions,	b Due to (or as a nonsequence of):			
60, Consider and be executed burial-transit	Examiner	It any, leading to turnediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a consequence of):			
	dicair		. d.			
	Пуме	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delive	iry
P.O. Be thet the death ed by the attended for	by Physician/Me	in the past 12 months? 1 ☐ Yes 2. ☑ No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		Month	Day Year
Division of Vital Records, P.O. Box 6 or attending Physicien: The law requires that the death certificate has been signed by the attending if in by the funeral director, page 2 should be detached for use as	Dy P	Part II. Other significant conditions of Endstack Renal	ontributing to death but not resulting in the underlying cause given in Part I.		acco use contribute to th	
ecord	Completed	Chospan Person	175000 1	1 ☐ Yes 24a. Was an		ably 4 Unknown  by findings available inpletion of cause of
Vital Reinicien: The lav	E			autopsy perform 1 Yes 2	ed? prior to condeath?  No 1 Yes	
Of Vita Physicien this certifical director	io pe	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ath <i>Check only one</i> Home 5 Resider	nce 6 Other (Specify	·)
oding Plus.: After the funera	IIIOn:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?  M   1   Yes   2   No	28d. Describe how	w injury occurred	
or Attended of Att	Certification:	3 Suicide 6 Could not be determined		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
_ ar s = 0		(Check only 2 Medicat Example (Check only 2 Medicat Example )	ysician: To the best of my knowledge, death occurred at the time, date and place inner: On the basis of examination and/or investigation, in my opinion, death occurred.	e, and due to the cau	use(s) and manner as st	ated.
To the h within 24	Medical	one) 29b. Signature and title of certifier	and manner stated.  29c. License number		d. Date signed (Month,	
		> Complete A	edical House officer 1945148		ebruary, 12	12006
3		KICARDO OSORNO,	completed cause of death (Item 23a) (Type, Print)  SM SECULIS Hospital, 2000 West Bultimoval ST	reet, Bulti	more, Marylan	nd 21223
State Registra		31 Date filed (Month, Day, Year) FEB 1 5 200	32. Registrar's Signature			

			For State Registrar	State of Mary		partment of I			giene	06	04296
			Decedent's Name (First, Middle, L.	ast)				2. Date of Dea	th	Year	3. Time of Death
	Physicia /Medic		KAREN		1	HTJOH	AUS	Month FEBILUI	ARY 10	1006	16:00 PM
	Examin		4a. Facility Name (If not institution, gi	ve street and number)	al	4b. City, Town,	or Location of Dea	th	4c. County	ol Death	
	Funeral		Social Security Number 6.	Sex 7. Age (III	n yrs. last birthda	/) If Under 1 Year Months Days			Year)	9. Birthp	lace (State or Foreign
	Director		094-70-0983 Usual Residence of Decedent	1   M 2   2   1	37 Yrs.			Aug. 5,		Eng	land
	land ow	Ì	10a. State 10b. County	10	c. City, Town or I	ocation				1	0d. Inside City Limits
	Man)	į	Maryland Harford	1	Abingdo	าท					1 ☐ Yes 2X No
	th the	Director	10e. Street and Number			10f. Zip Code		,	0g. Citizen of	What Cour	ntry?
	ath wi	rai	531 Constant Ric	lge Court		21009			USA		
0000	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "naturel" or items 23e or 28s-f ehow eny injury or other traumatic event, the Modical Examinar must be motified at once.	by Funerai	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☒ Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2  No If Yes, Give Year or Dates:	r in U.S. 13	Was Decedent of If Yes, specify Cub 1 ☐ Yes 2 ▼No	an, Mexican, Pue	Specify Yes or No- rto Rican, etc.)		ce - Americ ck, White,	etc.
Ş	2 hour		15. Decedent's	ducation	16a. Dec	edent's Usual Occu	pation		16b. Kind of 8		nite dustry
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7	ad with	Com	Listing italy/3000 italy (0°12)	5+	Socia	al Worker	Supervis	sor	U.S. Go	overn	ment
and	be file tal Hy d oth	Be (	17. Father's Name (First, Middle, Las	t)			18. Mother's Na	me (First, Middle,	Maiden Sumai	ne)	
<u>ya</u>	Ment Ment Marke Marke	၉	u/k		11/k		Sandra	u/k		Her	
Mar	12 sh h and 7 is m reum		19a. Informant's Name/Relationship			ling Address (Stree					
ָם ב	1 and Healt em 2		Robert A. Holthau 20a. Method of Disposition			L North Range of	ange Way	Beverly	Hills 20c. Location		cida 34465 own. State
5	ages int of t: If it		1   Burial 2 □ Cremation 3	☐Removal from State	cemetery, cr	ematory or other pla	1			,	
Баппо	artme ortani injury	1	* 4 □ Donation 5 □ Other (Spec 21. Signature of Furgeral Service Lic			ishford Co 22. Name and Addr		L8/06 McComas	Omro, V		
Ö	Depa impo eny ii		Fille Mon	1)	(	1317 Coke	-				
	*		23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that caused the	death. Do not e					-	Approximate Interval Between
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X O O	es that the death certifi igned by the attending be detached for use as		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p					23d. Da	ate of delive	эгу
ň	death e atte	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☒ No	1 ☐ Live birth 2 [ 4 ☐ Pregnant at tim 9 ☐ Unknown		☐Ectopic pregnand ☐ Other (specify) _		· -	М	onth	Day Year
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<u> </u>	requires that een signed b nould be deta	by	Part II. Other significant conditions	contributing to death but n	ot resulting in the	underlying cause g	ven in Part I.				he cause of death?
oro	w require been si should I	ted						1 D Y	es 2 0 No	3   Prot	pably 4 Unknown
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-	sician: The law certificate has b irector, page 2 s		05.44					1 Yes	200 No	1 🗆 Yes	2 🗆 No
VITA	sicial	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	2 ER/Outpati		hoc	eath (Check only or		(0	
Ö	y Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c. Inju	iry at	Home 5 Resid			y)
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UNISION	r Atte er de: recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine	d 28e. Place of Injury building, etc. (	- At home, larm,	street, lactory, office		281. Location (S City or Tow	treet and Num	ber or Rura	al Route Number,
5	ital or ris aft	Cer									
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Lifector: Atter this certifical completely filled in by the funeral director.	Medical	29a. Certifier (Check only one)  Certifying I	Physicien: To the best of n eminer: On the basis of ex and manner stated	amination and/or	ath occurred at the t investigation, in my	ime, date and place opinion, death occ	e, and due to the curred at the time, c	ause(s) and material and place,	anner as s , and due to	tated. o the cause(s)
	To the To the Comp	Σ	29b. Signature and titte of certifier				se number		29d. Date signi	ed (Month,	Day, Year)
	1		Huminan				-000		EBRUA	ry 1	0,2006
	15		LIG JOHNS HOL		12						
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			For State Registrar	State of Maryland		ent of He			iene	01297
	Physici	an	1. Decedent's Name (First, Middle, Last)	Hopkins			2	2. Date of Deat Month	h Day Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not Institution, give s University of Mary).		46. C	P 11.	ocation of Death	1 Character	4c. County of Dea	
	Funeral Director		5. Social Security Number 6. Sex 215-78-4724		t birthday) If Un Yrs. Monti	der 1 Year	If Under 24 Hrs.   8 Hours Min.	B. Date of Birth (Month, Day,		thplace (State or Foreign ountry) aryland
	yland how		Usual Residence of Decedent  10a. State 10b. County	10c. City, 1	Town or Location					10d. Inside City Limits
	the Mar 28a-f sl	Director	Maryland Harford	Da	arlingto				0g. Citizen of What C	1 ☐ Yes 2 ☑ No
	h with 23a or		2270 Price Road		101.	Zip Code 21	1034	'	USA	ountry
920	J within 72 hours after death with the Maryland jiene. I than "natural", or Itams 23a or 28a-f show the Medical Examinational De notified at	by Funeral	11. Marital Status  1 Never Married 3 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1		cedent of Hisp specify Cuban,	panic Origin? (Spec Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi Specify:	
7	C 2	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed)  College (1-4or 5+)	life. DO NO	work done dur Tuse retired)	ion ring most of working	7	16b. Kind of Business	/Industry
ld 21	e filed with Il Hygiene. other ther vent.	Be Co	17. Father's Name (First, Middle, Last)	<u> </u>	Homemak		8. Mother's Name (	First, Middle, I	Own Home Maiden Sumame)	3
Maryland	Menta Menta Brkad	To B	William Durham				Virgin:	,		
Mar	and 2 sho salth and n 27 ie m		19a. Informant's Name/Relationship (Ty) Mike Hopkins / Hi		•	,			City or Town, State, Maryland	
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			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	e cause on each line.	Do not enter the r	7 Cokes node of dying,	sbury Road such as cardiac or	l, Abin	gdon, Mary	Approximate Interval Between Onset and Death
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ecords, P.	w requires that the bean signed by should be detact	by	Part II. Other significant conditions cor	ntributing to death but not resulti	ing in the underlyir	ng cause given	in Part I.		bacco use contribute t	o the cause of death?
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Division	ial or Attendii s after death. al Diractor: A ed in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury · At hom building, etc. (Specify)	e, farm, street, fac	tory, office	28	Bf. Location (Si City or Town	treet and Number or F n, State)	iural Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To tha Funaral Diractor: After th completely tilled in by the funeral	edicai	29a. Certifier (Check only one) 12 Medical Exami	sici <b>an:</b> To the best of my knowle ner: On the basis of examination and manner stated.	n and/or investiga	tion, in my opir	nion, death occurre	d at the time, d	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
)	To t To t	Σ	29b. Signature and title of certifier	lean MD		29c. License r	number 5886	2   F	9d. Date signed (Mon	th, Day, Year) 2 200 6
	17		211 2111	impleted cause of death (Item 2	(Type, Print)	trent	Rollin.	~ 1	11 717	01
	Sta Regist		31. Date filed (Month, Day, Year) FEB 1 5 2006	impleted cause of death (Item 2  MD ZZ S G  32. Registrar's Signatur	Ander	· root	DUIT ITTLE	, /	· · · · · · · · · · · · · · · · · · ·	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month February Day , 2006 Hanna, Sr. **Physician** Howard Joseph 17:50PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 24 Hrs. Date of Birth (Month, Day, Aug. 3 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year Months Days 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours XX M 2□ F 63 1942 Yrs. 578-54-5414 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c, City, Town or Location 10a State 10b. County r than "natural", or iteme 23s or 28s-f ehow the Medical Exeminer must be notified at 1 ☐Yes 2 No Waldorf Maryland Charles Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code U.S.A. 20601 2845 Homette Place Funerai Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Named Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. It was once. Painting Painter 9th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Anna Mae Kennedy Joseph Howard Hanna, Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2845 Homette Place Waldorf, Maryland 20601 (WIfe) Ella Hanna 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Feb. 113. 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Clinton, Maryland 2006 Lee Crematory 4 ☐ Donation 5 ☐ Other (Specify) Lee Funeral Home, Inc. 22. Name and Address of Facility 21. Signature of Futheral Service Licenses 6633 Old AlexandriaFerry Road Clinton, MD 20735 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine use as the burial-transit or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-trai that initiated events resulting in death) Last Due to (or as a cons Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐ Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: Certification: To 1 Yes 2 No 1 Inpatient FUOutpatient 3□ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.
To the Funeral Director: After this completely filled in by the funeral di 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Injury 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 🖄 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier renun 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7503 Surratts Road Clinton, Maryland 20735 Obafemi Opesanmi. 3. Registrar's Signature 31. Date filed (Month, Day, Year) FEB 1 5 State 2006 Brake Land Registrar

			1 - For State Registrar	State of Maryland	•	it of Health an	d Mental Hygie	2006	04299
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960	hours after death with the Maryland turel', or items 23a or 28a-f ehow at Examinat rrust be notified at	d by Fun	1 Never Married 2 Married 3 Devidowed 4 Divorced	Armed Forces?  1  Yes 2  No if Yes, Give Year or Dates:	If Yes, spe	cify Cuban, Mexican, P  2 No Specify:	uèrto Rican, etc.)	Black, White	
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			30. Name and address of person who	completed cause of death (Item	23a) (Type, Print)	2mc	100 € Car	roll St. S.	alisburymD 2 1801
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			1. Decedent's Name (First, Middle, Las						2. Date of De	ath	000	3. Time of D	Death
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3	) 10		30. Name and address of person who	completed sause of d				et Ra	ltimore,	Marvil	and 21	201	
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Registrar

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 2 2006 Year **Physician** 12 Elvera Delores Jones 11:55a <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hartford 392 Hillcrest Drive Aberdeen If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🙀 F Yrs. 213-30-0864 Director 1-5-35 Md Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 ☐ Yes 2 ▼ No Completed by Funeral Director Md. Aberdeen Hartford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 392 Hillcrest Drive 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes & You No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Peges 1 and 2 should be filed within 72 hours after o Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural, or Item any injury or other traumatic event, the Madical Examines ODES. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Specify: Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Supervisor Assemble Line 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gerald Myers Elsie Butler ဂ္ 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21001 392 Hillcrest Dr., Aberdeen, Md. ieror Jones, Sr. Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2-18-06 Trinity Cem. Dundalk, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Md. 21202 l ad wane March F.H. East 1101 E. North Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -nrdiamn C /Medical Due to (or as a consequence of). erioscleratic Cardiarmentar Disense er tensire Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last (or as a consequence of): Examiner Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 2 1 ☐ Yes 2 No 3 DOA 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification; 5 Pending investigation 1 KNatural 1 ☐ Yes 2 ☐ No 2 Accident in by the 6 Could not be determined 3 🗌 Suicide 28e. Płace of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Examiner nding physicien and use as the burial-transit to the Hospital or Attending Physician: The law requires that the death certificate be executed Records, P.O. Box 68760, attending | detached for signed I certificate Division of Vital After this certific funeral director. death. within 24 hours after deatl To the Funaral Director: filled

with the Maryland

Baltimore, Maryland 21215-0036

28a-f show

Items 23a

Medical

29a. Certifier

State Registrar

orge 31. Date filed (Month, Day, Year) 5 2006 The state of

29b. Signatere and the of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mecillo MO 32. Registrar's Signature

9 Light St. Baltimore MD 21230

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

026203

29d. Date signed (Month, Day, Year)

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	Physici /Medio		1. Decedent's Name (First, Middle, Last) Bar bar q		****	Jones		2. Date of Death Month	Day	Year 2006	3. Time of Death
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	Funeral Director			M 2∑F	50 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, November	<sup>Year)</sup> 1955	Mary.	
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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if item 27 is marked other then "natural", or items 23a or 28a-f show apprintury or other traumatic event, the Medical Exeminer must be notified at anone.	Funeral Directo	1924 Jasmine Road  11. Maritat Status  1 □ Never Married   200 Married	12. Was Decedent Ev Armed Forces? 1 □ Yes 2 🛣 No	ver in U.S. 13.	10f. Zip Code  21  Was Decedent of H If Yes, specify Cuba	222 ispanic Origin? (Sp in, Mexican, Puerto			e - America k, White, e	ın Indian,
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Baltimore,	I. Pages nment of rtant: if it ijury or o		1 ☐ Burial 2 【Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		Bayview C	matory or other place crematory	16,	uary 2006 B			
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of Vital	Physician: The this certificate h at director, page	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital:		nt 3□ DOA Oth	or	th (Check only one ome 5 ☐ Resider	-	er (Specify	)
Division o	Jing After fune	Certification:	27. Manner of Death  1 YNatural 5 Pending investigation  3 Suicide 4 Homicide 6 Could not be determined	28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	y - At home, farm, sti	M 1	yat k? Yes 2 ⊡No	28d. Describe how 28f. Location (Str. City or Town,	eet and Numb		Route Number,
٥	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical Cer	29a. Certifier 1 Certifying Phy. (Check only one) 2 Medical Exemi	sician: To the best of ner: On the basis of e and manner state	my knowledge, deat	h occurred at the tin	ne, date and place, pinion, death occur	and due to the ca	use(s) and ma	inner as sta and due to	ated. the cause(s)
	To the within ? To the comple	Med	29b. Signature and title of certifier  **John School**	al mo e	2h17		-000	F	d. Date signer	-y 12	2006
	7		30. Name and address of person who co John Schoenhard Mo 31. Date filed (Month, Day, Year)	ompleted cause of dea	ath (Item 23a) (Type, S Hopkins D	Print) Nospital, To	wer 110, P	loctors Lov-	1 <i>90,600</i> iN	wolfe	ZIZ87 Ballimor, HD
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 5 2006	32. Registrar	's Signature	P					

State of Maryland / Department of Health and Mental Hygiene 🗍 🗍 🔓 04303 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death February 13, 2006 Physician Augusta Jobe 9:45 Αм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hammonds Lane Nursing Center Anne Arundel Brooklyn Park 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F 213-01-7489 Yrs. Director 98 22,1907 February Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r then "neturel", or items 23s or 28e-f ehow the Medical Examiner must be notitied at 1 ☐ Yes 2 🔀 No Funeral Director Maryland Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 753 Hawthorne Road 21090 USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 ₩Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 years Switchboard Operator Martins Marietta 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) s 1 end 2 should be fi Health and Mental H tem 27 le marked ot William C. Strumke Dora A. Foltz 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a t: If item 27 le Linda Brandenburg Great niece 753 Hawthorne Road, Linthicum, Maryland 21090 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20c. Location - City or Town, State Pages 1 1 ★ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Depertment of Importent: If eny injury or once. Oak Lawn Cemetery Dundalk, Maryland 15, 2006 Connelly Funeral Home Of Dundalk, P.A. 21. Signature of Fugeral Service Licenses 7110 Sollers Point Road, Dundalk, Md. 23a. Part1. Enter the disease or complications that caused the death shock, or heart failure. Uist only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) Stage **Physician** 6 n. /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ♣ No
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 Other (specify) ed by the e o. 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 3 ☐ Probably 4 Dunknown 1 ☐ Yes 2 ☐ No Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? 20 No 1 Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? director 26. Place of Death | Check only on Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 20No Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 1 🗌 Yes this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After Certification: Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No neral Director: / 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 T Homicide 1 entifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) クィョイクラ WD f person who completed cause of death (Item 23a) (Type, Print) 21061 30. Name and address OBYWOOD ROAD MD 7845 3. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend item 5 per fh 9853 3-29-06 vt.
State of Maryland 7 Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** 7:40 A M 2006 -elmuany DOROTHY LEE JOHNSON /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Baltimore Sinai Hospital boltmore N/A If Under 24 Hrs. If Under 1 Year Months Days 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign
Country) **Funeral** Hours 1 ☐ M 2)( F VIRGINIA Yrs Director 80 AUG 14 1925 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director BALTIMORE MARYLAND N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or U.S.A. 21206 5659 KAVON AVENUE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: þ Specify: BLACK 3₩idowed 4 □ Divorced "natural" Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LAUNDRY PRIVATE 8th\_grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ages 1 and 2 should be fil nt of Health and Mental H: I: If Item 27 is marked oth JAMES HIGHTOWER KATIE E WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2501 Violet Ave. Apt 1102N, Balto., Md. 21215 Sarah E. Williams/Daughter other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages XXBurial 2 Cremation 3 Removal from State injury or permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) BALTIMORE NATIONAL 02-16-06 BALTIMORE, MARYLAND 21. Signature of Europa Sarvice Lidense 22. Name and Address of Facility
WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A.
1206 W NORTH AVENUE Mollin 23a. Part1. Energy disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 201515 **Physician** 1 day /Medical Due to (or as a consequence of): Examiner Metabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760. Physician/Medical the IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 No 1 Yes 2 No 1 ☐ Yes of Vital or Attending Physician: the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death. 2 Accident 6 Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by determined 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2 To the 29b. Signature, and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) lani Wordhaw and, RES-000 February S, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E DMIL WADHAWAN, MD SINGE 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 5

DHMH 17 Rev 1/2001

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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 04305 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death February 13, 2006 **Physician** Robert E. Kolb 9:40 /Medical 4a. Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day NOV. 28 9. Birthplace (State or Foreign **Funeral** <sup>°</sup>1925 1 MM 2 □ F 80 MaryTand Nov. 220-16-6396 Yrs. Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mentel hygiene. Important: if item 27 is marked other than "natural", or iteme 23e or 28a-1 ehov any injury or other traumatic event, Ita Madical Examinat must be notified at Md. Baltimore Baltimore 1 Yes 2K No Funeral Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1315 Glenmont Rd. 21239 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) +4 Elementary/Secondary (0-12) Engineering Chemical Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Karl William Kolb Minnie Marquerite Beall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1315 Glenmont Rd. Baltimore, Md. 21239 Mrs. Helen Kolb/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 2-17-06 Baltimore, Md. 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee once 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on Interval Bety Onset and Death Immediate Cause (Final disease or condition resulting in death) the head and neck Cancer o **Physician** years /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine anding physicien and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown After this certificete hes been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy performed 1 Yes 2 No Hospital or Attending Physicien: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Dother (Specify) has pice ၉ 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? Injury 1 Natural 5 Pending within 24 hours after death. To the Funeral Director; Aft completely filled in by the fur investigation 1 TYes 2 TNo 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the th 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier D 58303 February 14

State Registrar

A 355

6601 N. Charles ST Browne my 2 1200

30. Na and address of person who completed cause of death (Item 23a) (Type, Print)

mo

32, Registrar's Signature

CHARLES

31. Date filed (Month Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#18, perfH, 6552, 2/21/06 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 3. Time of Death Day Month Dorothy Larue Kahler /Medical February 10 2006 7:40 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death TOWSON 4c. County of Death GREATER BALTIMORE MEDICAL CENTER BALTIMORE 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 17,1911 Birthplace (State or Foreign Country) 1 ☐ M 2 ☐ XF Months Days Hours Director 212-01-9502 94 Maryland Usual Residence of Decedent 10a, State 10b. County ir than "natural", or itama 23a or 28a-f ahow The Medical Examinar must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 ☐ Yes 2 X No Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4803 Carroll Manor Road by Funeral 21013 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 3 XWidowed 4 □ Divorced 1 ☐ Yes 2 ☑ No Specify: White Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Depertment of Health and Abnuld be filed within Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic avant, Ins Magneta. Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname)
Annie Ruff Melvin Lindsay Anna Rupp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Dolores Kahler</u> Daughter 4803 Carroll Manor Road Baltimore, Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)
21. Signature of Experial Service Licensee 20c. Location - City or Town, State Loudon Park Cemetery 2-15-2006 Baltimore Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 23a. Part1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** INFARCTION MYOCARDIAL /Medical Due to (or as a consequence of): Examiner ARTEROSCLEROSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 204RS Examiner Due to (or as a consequence of): The law requires that the death certificate be executed ed by the attending physiclen end detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 ☐ Other (specify) Day Year 9☐ Unknown 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 2√No 3 ☐ Probably 4 ☐ Unknown hes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? certificate 2. No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No မ Other: 4 Nursing Home 5 Residence 6 Other (Specify) this After thi 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural s after de. 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in b a Funeral f Certifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Func

completely f (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00025538 tamer ATTENDING 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PETER 8320 BELLONA AVE SUITE 120 TOWSON MD. 21204

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

FEB 1 5 2006

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MHLER,

M.D.

32. Registrar's Signature

			For State	State of Marylan	d / Depa		lealth and M	lental Hygi	ene nn a	e.
	E		Registrar  1. Decedent's Name (First, Middle, Last)			tilicate of t	Dealii	2. Date of Death	, No.	3. Time of Death
	Physici		Anastasia Koutr	rakos				February	, □ay , 2Č	06 3:00 A M
	/Medic Examir		4a. Facility Name (If not institution, give st.			4b. City, Town, or	r Location of Death	, 62, 64, 5	4c. County of	
			14 Jonathans Court	5		Cockeys	ville		Baltimo	re
	Funeral		5. Social Security Number 6. Sex	7. Age ( <i>in yrs</i> . M 2 7 7 7 9		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	(ear)	Birthplace (State or Foreign Country)
	Director		134-42-7725 Usual Residence of Decedent	M 2X 79	Yrs.			March 7,	1926	"Greece
	yland		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	Mar a-t a-t	ctor	MD Baltimore	Coc	keysvi	11e				1 ☐ Yes 2 ☑ No
	ith the	Olre	10e. Street and Number			10f. Zip Code		100	g. Citizen of Wha	at Country?
	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. I have tarked other than "natural; or itams 23s or 28s-f show aumatic event, the Modical Examiner must be notified at	Funeral Director	14 Jonathans Court			21030			reece	
	ter de Itam	nu	11. Marital Status  1 Never Married 2 Married	<ol> <li>Was Decedent Ever in U. Armed Forces?</li> <li>1 ☐ Yes 2 ☐ No</li> </ol>	S. 13. \	Nas Decedent of H f Yes, specify Cuba	lispanic Origin? (Span, Mexican, Puerto	ecify Yes or No- Rican, etc.)		American Indian, White, etc.
36	urs af	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1□Yes 2⊠ No	Specify:		Specify:	white
0	72 ho	Completed by	15. Decedent's Educa (Specify only highest grade	ation	16a. Deced	tent's Usual Occup	ation	16	Bb. Kind of Busir	ness/Industry
2	ithin Mar	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	_		during most of work d)			
2	filed w Hygier other th		17. Father's Name (First, Middle, Last)		Seams	tress			lothing	
2	od be	Be C	George Kouris				18. Mother's Name	s (First, Middle, Ma [solougia		
2	should be and Mental marked o umatic ava	5	19a. Informant's Name/Relationship (Type	e. Print)	19b Mailin	nn Address (Street	and Number or Rura			ita Zin Cada)
Baltimore. Marvland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic av once.		John Koutrakos	/ son	14 Co	ckeysvill	le Road; (	Cockeysvi	lle, MD	21030
P.	of Hee		20a. Method of Disposition	20b. P	lace of Dispo	sition (Name of natory or other place		Date 20	c. Location - Cit	y or Town, State
<u>E</u>	Page nent ant: If ury o		1 XBurial 2 ☐ Cremation 3 ☐ Red 4 ☐ Donation _ 5 ☐ Other (Specify)			os Greek Cei		'06 C	ub Hill	
<u>=</u>	permit. Departimportimporti		21. Signature of Yuneral Service Licensee	6		Name and Addres		11	1050 Yo	
	005 e d		100, U.C	luy			Funeral			MD 21204
			23a. Part1. Enter the disease, or complications, or heart failure. List only one transdate Cause (Final	ations at caused the death cause on each line.					t,	Approximate Interval Between Onset and Death
0	Pnysician /Medical		disease or condition resulting in death)	-15chemic	Car	dione	papatny			years
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		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a consequ	uence of):					-
	nd	Examiner	Cause (Disease or injury that initiated events c.							-
3413	eath certificate be executed attending physician and for use as the burial-transit	I Ex	resulting in death) Last	Due to (or as a consequ	uence of):					
β 687	physicate t	dicat	d.						61	
200	certifi ding use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregna	ncv				004 Date -	
0 8	death a atter d for u	Iclar	in the past 12 months?	1 Live birth 2 ☐ Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date o Month	Day Year
=0	t the by the tacher	hys	9 Unknown	9□ Unknown						
N 9	and the d	by Р	Part II. Other significant conditions contr	ibuting to death but not resu	alting in the un	nderlying cause give	en in Part I.	23e. Did toba	cco use contribu	te to the cause of death?
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Record	e iaw i has b	Completed			·			24a. Was an autopsy	24b. Wer	e autopsy findings available to completion of cause of
- C	ician: The i certificate ha rector, page							performe 1 □ Yes 2		th? Yes 2□ No
Ş		00	25. Was case referred to medical examiner?  1 Yes 2 No	spital:		Othe	26. Place of Death	1		
7	Physer this eral di	0 :u	27. Manner of Death	28a. Date of Injury	28b. Time of	t 3 DOA 28c. Injury Work	4 ☐ Nursing Hor	ne 5 V Residence 28d. Discribe how		Specify)
	ttending F death. ctor: After the funer	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		k? Yes 2 □ No		,. ,	
195/21/A	or Attand after death Director: ,	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number o	r Rural Route Number,
Angsprin	To the Hospital or Attending within 24 hours after death of To the Euneral Director: After completely filled in by the fune								,	
E	Hosp 14 hou Fune tely fil	Medical	(Crack Grily   21   Madical Examine	r: On the best of my known	wadga death	construct at the three restigation, in my or	ie, data and place, opinion, death occurre	and due to the cau	s (3) and manner and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Mec	one)  29b. Signature and title of certifier	and manner stated.		29c. License				fonth, Day, Year)
	F 3 F 8		1 Mda-rla							
	10		30. Name and Sdress of person who com	pleted cause of death (ttem	23a) (Type I	Print)	0303	150	71 Vary	17 2000
	W '		ARON CHARL	/	01	N. Ch	ertes 5	T KM	tum	13 2006 m 212ey
	Sta	-	31. Date filed (Month, Day, Year)	2. Registrar's Signal	ture	AP 0				
	Registr	ar	FEB 1 5 2006	Show &	65004					

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 10,2006 **Physician** 0K 5:00 P. M JA KIM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 12633 WATERSPOUT COURT OWINGS MILLS BALTIMORE | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 11-03-1937 5. Social Security Number Birthplace (State or Foreign Country)
 KOREA 7. Age (In yrs. last birthday) **Funeral** 1 M 2/XF 68 Yrs. 217-11-1176 Director Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits or then "neturel", or iteme 23s or 28s-f show the Medical Examiner must be notified at MD. BALTIMORE 1 Yes X No Director OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12633 WATERSPOUT COURT 21117 KOREA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ★ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: KOREAN þ 3€ Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) 6 YEARS College (1-4or 5+) OWN HOME HOUSEWIFE 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important; if Item 27 is marked oth any injury or other traumatic event SIRB. 18. Mother's Name (First, Middle, Maiden Surname) ( UNKNOWN) (UNKNOWN) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SOON PARK ( DAUGHTER ) 12633 WATERSPOUT COURT, OWINGS MILLS, MD. 21117 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State OAKLAWN CEMETERY BALTIMORE, MARYLAND 02-13-2006 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 1050 YORK 22. Name and Address of Facility ROAD RUCK TOWSON FUNERAL HOME, INC. TOWSON, MD. 21204 (R.G.RUTH) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) GASTRIC **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially fist conditions, if any, leading to animodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). signed by the attending physiclen and dispersive detached for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has autopsy performed? Yes 2X No 1 ☐ Yes 2 ☐ No 1 Yes Division of Vital To the Hospitel or Attending Physician: within 24 hours after death.

To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) U 2006 D 25642 ed cause of death (Item 23a) (Type, Print) Charles St MD/6601 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death <sup>Day</sup>, 2006 Physician FEBRUARY L **KRAVETZ** MIRIAM 7:23 Ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ATRIUM VILLAGE OWINGS MILLS BALTIMORE 8. Date of Birth Month Day, Year) JUL. 16, 1914 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year if Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔽 F Days Hours Yrs. 053-09-4745 91 Director Usual Residence of Decedent 10a State 10c. City, Town or Location itam 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the Modical Examinar must be notified at 10d. Inside City Limits Director BALTIMORE 1 ☐ Yes 2 🛛 No OWINGS MILLS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4780 ATRIUM COURT #368 21117 USA Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Yes 2 🖾 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE Completed by Specify: 3 Nidowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY** MEDICINE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Majden Surname) Be HARRY DAVIS FRIEDA UNKNOWN ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HOWARD KRAVETZ / 2 BROOK HILL COURT - COCKEYSVILLE, MD 21030 SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial, 2 ☐ Cremation permit. Page Department of Important: If eny injury or once. CHEVRA AHAVAS CHESED 02/12/2006 RANDALLSTOWN, MD 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Funeral Service Licens 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician COPE /Medical Due to (or as a consequence of): Examiner hepatic encephalopath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ been sig Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? s certificate har lirector, page 2 Yes Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \( \bar{1} \) Nursing Home 5 \( \bar{2} \) Residence 6 \( \bar{2} \) Other (Specify) 1 Yes ٩ 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No filled in by the fi 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 and manner stated. 29b. Signature and title of pertifier 29c. License number D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 mainst. suite 200, Reisterstonn, N.S. Rajapakse,MD 31. Date filed (Month, Day, Year) 2. Registrar's Signature State Registrar

OFIL 06-00863 Unpend item# 23a,27,28a f,pen/E,0852,2/23/00 11
State of Maryland / Department of Health and Mental Hygiene Gary Lee 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent Tame (First, Middle, Last, 2. Date of Death 3. Time of Death Day **Physician** February 03, 2006 22:32 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bon Secours Hospital Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□ F 217-68-235 Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23s or 28s-f ehow may injury or other traumatic event, the Medical Examinat must be notified at once. 10d. Inside City Limits 1 Thes 2 □ No Completed by Funeral Director none 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 Yes No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 1 hnown (First, Middle, Last 18. Mother's Name (First, Middle, Maiden Be e 19b. Mailing Address (Street and Number or Rural Route Number, City or 503 20b. Place of Disposition (Name of 20a. Method of Disposition Method 5.

1 Burial 2 Cremation 5 Other (Specify) 3 Removal from State 21. Signature of Funeral Service Licensee 40 MD21229 O. Natron 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic and alcohol intoxication /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certification; To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): attending physicien and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 24b. Were autopsy findings available phor to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autoosy 2□ No is effer deam...
in Director: Affer this cer...
in by the funeral director, p? 1 Yes Division of Vital 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 □ No 1 ☐ Inpatient 2 ☐XER/Outpatient 3 ☐ DOA 28b. Time of Injury Fnd 27. Manner of Death 28a. Date of fnjury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 1 No 2/3/2006 Fnd 10:05 P 2 Accident 6 Could not be 3 Suicide To the Hospital or Atte within 24 hours efter de To the Funerel Direct completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 621 Appleton St. 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Baltimore, MD Found at home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signisture and titte of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 04, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARGARITO OREL 111 Penn Street, Baltimore, Maryland 21201

Registrar

State

31. Date filed (Month, Day, Year)

FEB 1

5 2886

32. Registrar's Signature

			1 - State Registrar	State of Maryland		artment of F			giene	36	043	
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath		3. Time of	Death
	Physicia /Medic		Charles	George		Lange		Februar	y 17, 2	0წწ	5:40	Рм
	Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, o		eath	4c. County	of Death		
			1410 Delvale Avenu			Dunda If Under 1 Year				imore	9	
	Funeral Director		5. Social Security Number 6. Sex 1 (2)	B. Date of Birth (Month, Day July 6	Pay, Year) Country)							
	land		Usual Residence of Decedent  10a. State 10b. County	10c. City	Town or Lo	cation					10d. Inside Ci	ty Limits
	Mary	to	Maryland Baltimor	e	Dunda	lk					1 🗆 Yes	2 ₹ No
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of N	What Cou	ntry?	
	23a		1410 Delvale Avenu	le		21222			U	SA		
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heath and Mentell Hygiene.  Misportant: If tier az 1 is marked other than "naturel", or items 23a or 28e-f show eny injury or other treumatic event, the Madical Examinant must be multiled at once.	by Funerai	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	<ul> <li>12. Was Decedent Ever in U.S Armed Forces?</li> <li>1 ☐ Yes 2 X No If Yes, Give Year or Dates:</li> </ul>	1	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2∏ No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No- erto Rican, etc.)	Blac	e - Americk, White, v:White		
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<u> </u>	should Ind Menion Menio	၉	19a. Informant's Name/Relationship (Ty)	pe. Print)	19b. Mailir	ng Address (Street		Rural Route Number	r City or Town	State Zii	n Codel	
e ∑	od 2 suith an ith an 27 is		John F. Dysard Sr.					et, Baltin				24
Ē,	S 1 er if Hea item othe		20a. Method of Disposition	20b. Pla	ace of Dispo	sition (Name of natory or other place		Date	20c. Location -			
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Balti	permit. Depertinitmports eny inju		21. Signature of Funeral Service License	Connel	ly 2	Name and Addre Connelly 7110 Soll	ss of Facility Funeral	Home of I	Dundalk	,P.A.	- A	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the death.							Approximate Interval Bets	ween
F	Physician		Immediate Cause (Final disease or condition	Antoniosch	1		vaseulo	1		- 1	Onset and D	Death AS
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):						1	
	- LAGIMINE!	_	Sequentially list conditions, if any, leading to immediate		onen of):					_		7.
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	ie dea the et hed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of dea	ath 5	Other (specify)			Mo	nth	Day Y	/ear
<u>~</u>	res that the de igned by the e be deteched f	P.	Part II. Other significant conditions con	tributing to death but not resul	ting in the u	adarhina cauco au	on in Part I	23e Did to	bacco use cont	nbuto to t	ho cause of d	oath?
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6	Physical direction	ည	1 Yes 2 No 27. Manner of Death		R/Outpatien		4 🗀 Mui Siriy	- / -	ence 6 Oth		fy)	
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Division of	or Attendi after death. Director: A in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At hor	ne, farm, str			28f. Location (S	treet and Numb	er or Rura	al Route Numi	ber,
á	s afte	Certification:	4  Homicide determined	building, etc. (Specify)				City or Tow	n, State)			
	Hoepi 4 hou Funer iely fill	edicai	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of my know er: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tin restigation, in my o	ne, date and pla pinion, death oc	ice, and due to the c curred at the time, d	ause(s) and ma late and place,	inner as s and due to	stated. o the cause(s)	)
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	Ġ.	1	30. Name and address of purson who co	mpleted cause of death (1 em	23a) Type,	Print)	, 401	The same of the sa	-eprua	1,	11 200	40
			Philip Militell		Total .	FILL CT. L	uthoru.	VE.MD	210	43		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 2006	32. Registrar's Signatu	TIE OF D			(				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra Amend Item #17 Per FH G852 3 Gestificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** NANCY LANASA 4:32 P FEBRUARY 13 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 407 CAMBRIA STREET BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Yea Feb. 25, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year) 1 ☐ M 2 ☑ F 219-50-4552 Yrs. Director 57 1948 Maryland Usual Residence of Decedent with the Maryland 10a State 10c. City, Town or Location 10b County 10d. Inside City Limits item 27 is marked other than "natural", or itams 23s or 28s-1 show other traumatic event, the Madical Examiner must be motified at N/A Maryland **Baltimore** 1 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 407 Cambria Street USA 21225 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status s 1 and 2 should be filed within 72 hours after if Health and Mental Hygiene. Item 27 is marked other than "natural", or itsi 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: δ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Arundel Recycling Floor Supervisor 12 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be George J. Revis Eileen C. Barringer Tom Arthur Revis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Anthony Lanasa, Sr. (Husband) 407 Cambria St., Balto., Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 ment of F tant: If its 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State
'4 ☐ Donation 5 ☐ Other (Specify) ö permit. Page Department of Important: If any injury or once. Holy Cross Cemetery 2/17/06 Baltimore, Maryland <sup>22</sup> Name and Address of Facility McCully-Polyniak Funeral Home, 237 E. Patapsco Ave., Balto., 1 21. Signature of Funeral Service Licensee Kevin E Ecker 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** tocellular carcinoma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnar 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Day 4□Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No Completed 24b Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed death? 2 No 1 Yes 2 ■ Hospital or Attending Physician: 24 hours after death. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation **Director**: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral C 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature apolitie of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 14, 2006 18807 who completed cause of death (Item 23a) (Type, Priet)

Hanover St., Battimore

Registrar
DHMH 17 Rev 1/2001

State

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day Year Physician ove Joy 2006 107 AM Jenni5 3 Rb /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Year If Under 24 Hrs. 8. Date of Birth
Days Hours Min. (Month, Day, Year)

SegT 15 191 Examiner BALTIMORE 6,11chresT HOSPICE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 2 F 65 522-52-5143 Usual Residence of Decedent Yrs Director 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Item 27 is marked other than "naturel", or Iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director MD BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21206 U. 5.A. 4616 ASSOT4 AUE Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Des 2 No U.S.
If Yes, Give
Year or Dates: NAVY 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: White 3 Widowed 4 Divorced NAVY Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) is 1 end 2 should be filed within theelth and Mental Hygiene. Item 27 is marked other than Beth Steele Corp. 12TL CRAIN OPERATOR NIA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DozieR LoveJoy Helen ( Ames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bolto. 21206 4616 ASbury Ave MD Atherine 0V < 50 4 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2/15/06 permit. Peges
Depertment of H
Importent: If Ite 12 Buriai 2 ☐ Cremation 3 ☐ Removal from State Balto-MA 4 □ Donation 5 □ Other (Specify) Cem OAKLAWA 22. Name and Address of Facility
PAUL STELLA FUNERAL HOME PA
7527 hereid Rs. Ballo MO 21. Signature of Funeral Service License aul M MO 21234 Lette 2a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** AV Kin Sons CARS resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Dualto (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-transit Due to (or as a consequence of): 68760. ed by the attending physicien detached for use as the buria Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 Yes 2 No P.0. 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, emptoma secondary To 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No this certificate Division of Vital director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) | DSPICE 1X Yes 2 No 2 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: Found wandering outside of Home with evidence of Fall

281. Location (Street and Number or Rural Route Number, City or Town, State) After 5 Pending investigation 1 Natural January 26,2006 uncertain M death. 1 ☐ Yes 2 No 2 Accident efter death filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours eff To the Funeral DI completely filled in Home Asbury Avenue, Baltimore, MD 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signalus an Ditle of certifier 29c. License number 118667

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Signature

Philip Militello, MD & Trimble Hill CT. Luthenville, Maryland 21093

February 15, 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 13, 2006 **Physician** Lewis, Jr. Steven Michael 6:15 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Hospice Timonium Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | NOV 22, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**∑**M 2□ F Director 218-13-6435 26 1979 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 705 Reedy Circle 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2X Married

9. Birthplace (State or Foreign r than "neture!, or items 23a or 28a-f ehow the Mudical Examiner must be notified at 10d. Inside City Limits 1X Yes 2 □ No 1 ☐ Yes 2 XNo If Yes, Give 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Substitute Teacher Education other Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Steven Michael Lewis, Sr. Vickie Lynn Skeens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is eny injury or other trea Nicole Lewis - Wife 705 Reedy Circle, Bel Air, Maryland 21014 Baltimore, 20b, Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 2/16/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Makt-7 50 West Broadway Street, Bel Air, MD 21014 23a. Part 1. Enter the disease or combications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) **Physician** HODG KINS LYMPHOMA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of): Examine use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): ettending physicien Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month 5 Other (specify) P.O. 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 5 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate Vital 1 Yes 2 No 1 ☐ Yes : After this certifice e funeral director, r Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 No Certification: To HOSPICE ŏ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No 3 ☐ Suicide W

Hospital or Attending Physician: Division hours after death To the Hospital or Atterwithin 24 hours after des To the Funeral Directo completely filled in by th

6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43725 2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

State

Registrar

31. Date filed (Month, Day, Year)

MAHMOOD, MD. FEB 1 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

within 24 hours : To the Funerel I To the Hospital

> State Registrar

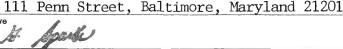
31. Date filed (Month, Day, Year) 5

29b. Signature and title of certifier

30. Name and address of per



son who completed cause of death (Item 23a) (Type, Print)



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

February 13, 2006

			1 - State of Ma	aryland / Depa	artment of He			ene	6 01	1317
	Physic		Decedent's Name (First, Middle, Last)	an			2. Date of Death Month FEB.	Day	Year	Time of Death 8:15P M
	/Medi Exami		4a. Facility Name (If not institution, give street and number)	MII.	4b. City, Town, or Lo	ocation of Death	red.	4c. County		8:158
	and the same	de C	4720 Meise Avenue		Baltimor			Bal:	timore	
Т	- Funeral		5. Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year	f Under 24 Hrs.	8. Date of Birth			(State or Foreign
	Director		220~40~7858 XIM 2 IF	63 yrs.	Months Days	Hours Min.	June 19,	1942	Maryl	and
	p .		Usual Residence of Decedent  10a. State 10b. County	10- 0i- T						
	anyla sho	ž	,	10c. City, Town or Lo						iside City Limits
	the Marylar 28a-f show	ecto	Maryland Baltimore	Baltır	more Count	у				Yes 2X No
	Mith 1	Director	10e. Street and Number	1	10f. Zip Code	_	10	g. Citizen of W	hat Country?	
	eath w	erai	4720 Meise Avenue	i=11.6	2120		7 14	USA		
	itema itema	Funerai	11. Marital Status  12. Was Decedent E Armed Forces?	verin U.S. 13. v	Was Decedent of Hisp f Yes, specify Cuban,	anic Origin? (Spe Mexican, Puerto I	Rican, etc.)		- American Inc. c, White, etc.	dian,
336	ours atter death with the Maryla ret', or Itema 23a or 28a-f shov Examiner must be mullisted	by	Armed Forces?  1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Narried 1 Never Married 1 Never Married 2 Narried 1 Never Married 2 Narried 1 Never Married 2 Never Married 1 Never Married 2 Never Marri	Ľ962~ 1	I□Yes 21X No	Specify:		Specify:	Whit	е
ŏ	be filed within 72 hours after death with the Maryland lal Hygiene. d other than "naturel", or itema 23a or 28a-f show event, the Madical Examble must be mullised.		15. Decedent's Education	16a. Deced	lent's Usual Occupation	on	1	6b. Kind of Bus		
215	Madi	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  Colfege (1-4or 5-	(Give I	kind of work done dur. DO NOT use retired)	ing most of worki	ng		,	
21	giene Th	Ю	12 yrs. N/A		) Mechanic			B. G.	& E.	
B	al Hy s oth	Be (	17. Father's Name (First, Middle, Last)		18		(First, Middle, M		9)	
<u>la</u>	should bank and Mente marked umatic e	To	Hugh McGowan			Doro	thy Scho	ltz		
Maryland 21215-0036	s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Madical	1	19a. Informant's Name/Relationship (Type, Print)	19b. Mailin	g Address (Street and	d Number or Rura	Route Number,	City or Town, S	State, Zip Code	)
	and and n 27		Patricia J. McGowan (Wife)	4720	) Meise Av	enue Bal	timore,	Md. 212	206	
altimore,	ges 1 it of Hi if ite.		20a. Method of Disposition  XX Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispos cemetery, crem	sition (Name of natory or other place)	D	ate 2	0c. Location - 0	City or Town, S	tate
Ĕ	Parit Parit		4 Donation 5 Other (Specify)	Parkwood	Cemetery	2-17	~06	Baltimo	ore, Md	
Balt	permit. Page Depertment o importent: If eny injury or gitte.		21. Signature of Funeral Service Licensee	22. L	. Name and Address of Lassann Fur	neral Ho	me Ral	l Belai timore,		1236
	Physician /Medical Examiner	er	Sequentially list conditions b.	the death. Do not entered.		such as cardiac o	r respiratory arres	st,	Inter	oximate val Between et and Death
38760, <	icate be executed physicien and s the burial-transit	dicai Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	consequence of):						
P.O. Box 6	law requires that the death certifit as been signed by the attending t 2 should be detached for use as	by Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No	Petal death 3	Ectopic pregnancy Other (specify)			23d. Date Mont	of delivery th Day	Year
	requires tha been signed should be del	ed by	Part II. Other significant conditions contributing to death bu	not resulting in the un	derlying cause given i	n Part I.	23e. Did toba 1 ☐ Yes	cco use contrit		se of death?
Vital Records,	The ete h page	Completed					24a. Was an autopsy performe	24b. W pr de 2No 1	ere autopsy fin ior to completio eath?	ndings available on of cause of
/ita	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?		26	6. Place of Death	Check only one			
	Physic this c	2	1 ☐ Yes 2 No Hospitaf: 1 ☐ Inpatien				ne 5 Residen	ce 6 Other	(Specify)	
Division of	ng lifte	Certification:	27. Manner of Death 1 Natural 5 Pending 28a. Date of fnjury (Month, Day)	Year) 28b. Time of Injury	28c. Injury at Work?	2	8d. Describe how	infury occurre	d	
sio	deeth. deeth. ctor: A y the tu	cati	2 Accident investigation			2 🗆 No				
Ξ	or Attender der Director in by the	E	4 Homicide determined 28e. Place of Injury	y - At home, farm, stre (Specify)	et, factory, office	2	<ol> <li>Location (Streetly or Town,</li> </ol>	et and Number State)	or Rural Rout	e Number,
	lospital or Al hours after of unersi Directly filled in by									
	To the Hospital or Attentwithin 24 hours after deet To the Funeral Director: completely filled in by the	Medicai	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner stat	examination and/or invi	occurred at the time, estigation, in my opini	date and place, a on, death occurre	nd due to the cau d at the time, dat	ese(s) and man e and place, ar	ner as stated. nd due to the ca	ause(s)
	With To	2	29b. Signature and title of certifier	ul w	29c. License no	38/		d. Date signed	(Month, Day, Y	2006
	6H		30. Name and address of person who completed cause of de	ath (Item 23a) (Type, P	Phila de	Johna Ro	1, #304	1 Ball	morem	D21237
4	Sta Registr		31. Date filed (Month, Day, Year) 32. Registral	's Signature	Coales	1				
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			1- State of Maryland / Department of Health and Certificate of Death	•	giene Reg. No.	04318
	Physici		Decedent's Name (First, Middle, Last)     RITA DORIS MILLER	2. Date of De. Month Februar	Day Year	3. Time of Death 3:42 PM
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of De  Good Samarikan Hospital  5. Social Security Number 6. Sex 1 M 2 N F 87 Yrs.  4b. City, Town, or Location of De  Ballimore  If Under 1 Year If Under 24 H  Months Days Hours Mi	ath  rs. 8. Date of Birt	4c. County of Dea	ath
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
	e Mary Be-f sh	Director	Maryland Baltimore City Baltimore City			1X Yes 2 □ No
	ath with the 23a or 2 mail be no	rai Dire	4309 Forest View Avenue 10f. Zip Code 21206		10g. Citizen of What C	
980	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If man 27 is marked other than "natural", or Itame 23a or 28e-f show other treumatic event, the Madical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Foxes?  1 □ Yes 2 ☑ No If Yes, Sive Year or Dates:  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put If Yes, Give Year or Dates:	(Specify Yes or No erto Rican, etc.)		
15-0	in 72 h	Completed	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of wife. Do NOT use retired)	vorking	16b. Kind of Business	/Industry
212	ed with giene. er ther	Comp	12 yrs.   College (1-4or 5+)   Salesperson/Secreta		Catering	Business
Maryland 21215-0036	d be file ental Hy ted oth	Be			Maiden Sumame) Ude Laragy	
aryl	2 should be and Mental is marked c	2	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or a	Rural Route Numbe	er, City or Town, State,	Zip Code)
pol .	1 and 2 Health em 27 i	1	JoAnn Miller (Niece) 117 Shell Cove Ct. 20a. Method of Disposition (Name of	Joppa, Md	. 21085 20c. Location - City or	Town State
Baltimore,	Page nent c ant; if ury or		**Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  **Commetery, crematory or other place)  **Most Holy Redeemer 2	11~2006	Baltimore,	
Bal	permit. Departr Importa		21. Signature Fineral Service Licenses Cassann Funeral Lassann Funeral Lassann Rd. E	Home Baltimore	, Md. 21236	6
	Physician /Medical		23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardishock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		rest,	Approximate Interval Between Onset and Death
ı	Examiner	_	Sequentially list conditions, if any leading to immediate  b. Upper Gastro Intestinal Bi			
V	outed of ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	arction		
68760,	tificate be executed g physicien and as the burial-transit	edical Exa	resulting in death) Last  Due to (or as a consequence of):  d.			
		/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
.O. Box	that the death cert ed by the attendin detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 ☑ No 9 ☐ Unknown		23d. Date of de Month	livery Day Year
ds, P	w requires that been signed I should be det	þ	Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.  Hyperken Sion	23e. Did to	obacco use contribute to res 2⊠No 3□P	o the cause of death?
of Vital Records, P.O.	W CV	Completed	Atrial Fibrillation	24a. Was autop perio 1 🗆 Yes	rmed?   death?	utopsy findings available completion of cause of
Vita	gicien: The sectificate lirector, pag	o Be	examiner?	eath (Check only o	ne) dence 6 □Other (Spe	noite)
n of	ng Phys	-	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Injury Work?		now injury occurred	City)
Division	To the Hospitel or Attending Phygicien: The within 24 hours efter death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	2 Accident investigation 3 Suicide 4 Homicide determined 288. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	Street and Number or R vn, State)	ural Route Number,
,	s Hospita 24 hours e Funere etely fille	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and pla 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ce, and due to the curred at the time,	cause(s) and manner a date and place, and due	s stated. e to the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier M.D. 29c. License number RES CO	B	29d. Date signed (Mont February,	
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Khaled H9SSan 5601 Lach Raven Blvd. Balkimon	re, MO	21239	
	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Khaled Hassan 5601 Lach Raven Blvd. Balkimon  31. Date filed (Month, Day, Year)  FEB 1 5 2006  Some M. Signature			

**Physician** 

/Medical

Director

Be Completed by Funeral

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examination is used by notified at once.

4 - Homicide

	Plea	ise Type or						_		_	jible.	
For State Registrar		State	of Mary	land / Dep	artment o			lental Hy	_ (	JUL	)6	04319
1. Decedent's Name	(First, Middl	le, Last)						2. Date of De				3. Time of Dea
	chard N	Maresh n, give street and no	imbor)		4h Cib. To		/ D	Februa		)ay12	2006	
VA Maryla	nd Hea	lth Care		m	4b. City, Tov Peri	y Poi			4	Cec	ty of Death il	1
. Social Security No. 486 34 7643  Jsual Residence of	3	6. Sex 1 ☐ M 2 ☐ F	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Y Months D	ear If Ur ays Hou	ider 24 Hrs. Irs Min.	8. Date of Bi (Month, Da May 15	ay, Yea	ır)		nplace (State or For untry) IV, WISCONSIT
0a. State	10b. County		100	c. City, Town or Lo	ocation							10d. Inside City Lin
Maryland	Baltimo	ore		White Man	rsh							1 Yes 2
0e. Street and Num 11315 Vince		ł			10f. Zip Co 21162				-	Citizen of	What Cou	untry?
1. Marital Status		If Yes. G	orces? 2 □ No ive		Was Decedent If Yes, specify			ecify Yes or No Rican, etc.)	0-		ack, White	ican Indian, , etc.
3 XWidowed	15. Deceden	Year or I	Dates: KO	rean     16a. Dece	dent's Usual O	ccupation			16b.			ite ndustry
Elementary/Secon		/	1-4or 5+)	life.	kind of work d DO NOT use n	etired)		ing				,
8 NA Heavy Forinment Repair Constructio 17. Father's Name (First, Middle, Last)  NA Heavy Forinment Repair Constructio 18. Mother's Name (First, Middle, Maiden Sumame)									Co			
Joseph Ma							olet R					
9a. Informant's Na Joyce Bake		thip <i>(Type, Print)</i> ehter)			ng Address <i>(St</i> Vincent			a <i>l Route Numb</i> Marsh, M				p Code)
0a. Method of Disp	osition Cremation	3 □Removal from	State	Ob. Place of Disponentery, cree	sition (Name on matory or other	f place)	1	Date	20c.	Location	- City or T	own, State
21. Sture of Fur	4%		<u> </u>	22	Name and A assahn F	ddress of Fa	acility		Ba	LEIMOI	re,Mar	y.Land
3a. Part1. Enter th	e disease, or t failure. List	complications that	caused the each line.	death. Do not en	401 Bela	aying, suc	l Baltir	Prespiratory a	ylar	rd 212	236	Approximate Interval Between
mmediate Cause (F lisease or condition esulting in death)	Final 1	a		e Acute Myocardial Infarction								Onset and Death Unknown
equentially list con any, leading to im- ause. Enter Under ause (Disease or in	mediate tving	b. Due to	(or as a consequence of):									
hat initíated events esulting in death) Li	ast	c. Due to	(or as a cor	a consequence of):								
F FEMALE: 23b. Was decedent in the past 12 r 1  Yes 2  9  Unknown	nonths?		oirth 2 🗌 nant at time	Fetal death 3	Ectopic pregn						ate of deliv	ery Day Year
art II. Other signific	cant conditio	ons contributing to d	eath but no	t resulting in the u	nderlying cause	given in Pa	art I.	23e. Did t	obacco	use con	tribute to I	he cause of death?
Chronic								1 🗆 '	Yes	2□No	3 □ Prot	bably 4 🛣 Jnkno
Prostate	Cance							24a. Was autor perfo	psy prmed?		Were autoprior to codeath?	opsy findings availa ompletion of cause
5. Was case referre examiner? 1 \( \text{Yes} \) 2\( \text{Yes} \) 1		Mosnital:	Inpatient	2 ☐ ER/Outpatien	t 3□ DOA	0.1		(Check only o	one)			
7. Manner of Death 1 Natural		g 28a. Date (Mon	of Injury th, Day Yea		28c.	4A njury at Work? 1 ☐ Yes 2		me 5 Resi 28d. Describe				TY)
2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 Could in determ	not be 290 Place	of Injury -	At home, farm, str				28f. Location (	Street a	ınd Numi	ber or Rura	al Route Number,

**Physician** /Medical Examiner Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed the attending physician and the for use as the burial-transit Division of Vital Records, P.O. Box 68760. within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a compietely filled in by the funeral director, page 2 should be detached.

Medical Certification; To Be Completed by Physician/Medical

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier

29c. License number D24648

29d. Date signed (Month, Day, Year) 2/12/06

21902

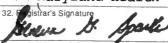
28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sher A. Hashmi, M.D. VA Maryland Health Care System Perry Point, MD

31. Date filed (Month, Day, Year) FEB 15

2006



28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Registrar

			1 - For State Registrar	State of Mai	ylan		artmen tificate			nd M	ental H	lygie,	$Z \prod$	06	043	20
	Physici	an	Decedent's Name (First, Middle, Last,	)							2. Date of I		Day	Year	3. Time	of Death
	/Medio		WILLIAM FRANC	IS MORAN,	JR.					1	Februa	ary	12,	2006	3:	55 A <sup>M</sup>
~	Examir	er	4a. Facility Name (If not institution, give						ocation of	Death				inty of Death		
	- Table - 1	A.	FREDERICK MEMO					REDER						REDERI		
	Funeral		5. Social Security Number 6. Sec	X 7. Age		ast birthday) Yrs.	If Under Months	Days	Hours	Min.	8. Date of l	Birth Day, Ye	ar)	COL	u <i>ntry)</i>	e or Foreign
· -	Director		220-30-9591 Usual Residence of Decedent		80	113.				1	May 1	, 19	25_	Mary	land	
	/land		10a. State 10b. County		10c. City	, Town or Lo	cation								10d. Inside	City Limits
	Man-feh fied	ţ	Maryland Frederick	102	roda	ioal. U	od och t	0							1 🔀 Y€	es 2 No
	r 28e	Directo	10e. Street and Number		Lauc	lock H	10f. Zip					10g.	Citizen	of What Cou	untry?	
	n with	0	6612 Jefferson Bou	1 award			2171	7				US			,	
	deetl	by Funeral	11. Marital Status	12. Was Decedent Ev	er in U.	S. 13. V			panic Origi	in? (Spec	cify Yes or I		_	Race - Amer	ican Indian,	
9	after or Ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 📉 No						Puerto F	Rican, etc.)		1	Black, White	, etc.	
21215-0036	within 72 hours after deeth with the Maryland ene. than "naturel", or Items 23s or 28e-f ehow ha Medical Examinat must be notified at	d b	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□ Yes 2	ZIŽĮ NO	Specity:				Spe	cify: Whi	te	
5	72 h 'natu	Completed	15. Decedent's Edu (Specify only highest grad			16a. Deced	lent's Usua	l Occupat	ion iring most o	of workin	0	16b	Kind o	f Business/I	ndustry	
2	ithin De. Han	ldu	Elementary/Secondary (0-12)	College (1-4or 5+)		life. L	OO NOT us	e retired)	3		3					
	filed w Hygier other ti	Ö	8			Owner									ng/Iro	on For
ng	be first H do off	Be	17. Father's Name (First, Middle, Last)								(First, Mida			name)		
Ž	2 should be a nand Mental I is marked o raumatic eve	2	William Francis Mo								Reid 1					
Maryland	s 1 and 2 should be filed within 72 hours after deeth with the Marylar if Health and Menial Hygiene. Item 27 is marked other than "naturel", or Items 23s or 28e-f ehow other traumatic event, the Medical Exactinal must be notified at		19a. Informant's Name/Relationship (Ty											wn, State, Z		
	1 and 2 Health em 27		E. Jay Hendrickson	, Personal					er Cre							703
0	ges t of h if ite		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ F	lemoval from State	20b. PI	ace of Dispo: em <i>etery, cre</i> n	sition (Nam natory or of	ie of her place)	)	Da	ate	20c.	Location	on - City or T	Town, State	
Ē	E Pa tmen tent:		4 □Donation 5 □ Other (Specify)		Smi	thsbur								burg,		
Baltimore,	permit. Pages : Department of H Importent: If Ite eny Injury or ot		21. Signature of Funeral Service Licens	90		22	. Name an	d Address	of Facility	Keen	ney ar	nd B	asf	ord Fu	meral	Home
	405 • d		Kyan M. D		M005	999   10	06 Ea	st Ch	nurch	Str	eet, ]	Fred	eri	ck, MI	217	
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only or	ications)that caused the caused the	e death	. Do not ente	er the mode	of dying,	such as ca	ardiac or	respiratory	arrest,			Approxim Interval B	letween
à	Physician		Immediate Cause (Final disease or condition	METAS	7777	IC (	06	NI C	ANC	FR					Onset and	d Death ARS
	/Medical Examiner		resulting in death)	Due to (or as a				7						1	7 / /	1112
×	ZAGIIIIIO	_	Sequentially list conditions, if any, leading to immediate	o. ———————												
7	ed sit	Examiner	cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequ	ence of):										
	end I-tran	хал	that initiated events resulting in death) Last	Due to (or as a	20000000	anos of):										
8760,	be executed sicien end burial-transit	a E		Due to (or as a t	Jonsequ	erice or).										
87	hy:	by Physician/Medical		i											. <u></u> .	
9 ×	ires that the death certific signed by the attending p d be detached for use as	/Me	tF FEMALE:	3c. If yes, outcome of	pregnar	2014										
Вох	atten for u	lan	in the past 12 months?	1☐Live birth 2 4☐Pregnant at tir	Fetal	death 3 🗆	Ectopic pre							Date of delive Month	very Day	Year
ó	the d	yslo	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ne or de	ain 5	Other (spe	эспу)							,	
من	that ed by deta	표	Part II. Other significant conditions cor	tributing to death but	not resu	tting in the un	derlying ca	use diven	in Part I		23a Dio	d tobacc	O USA C	ontribute to	the cause of	f death?
ds	sign sign d be	9					, , ,					] Yes			bably 4	
Ö	w requir been si should	ete								_	-					
Re	he lav	Completed								_	24a. Wa	opsv		b. Were aut	opsy finding ompletion of	s available cause of
a	n: Th										1 Tes	formed	No	death?	2 🗆 No	
Ĭ	certification	Be	25. Was case referred to medical examiner?	lospital:				A Other:			(Check only					
ō	Phys r this ral di	٠. ت	1 Yes 2 No	1 Inpatient 28a. Date of Injury		ER/Outpatient 28b. Time of			4 🗀 INUIS					Other (Speci	ify)	
Ö	ding h. After fune	E l	1 Natural 5 ☐ Pending	(Month, Day Y	'ear)	Injury	M	Bc. Injury a Work?			Bd. Describe	e now in	jury oc	curred		
Division of Vital Records, P.O.	deat ctor: y the	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury	- At hor	me farm etre			s 2 No	-	Pf Location	/C+== =+	n of 81.		10 11	
<u>S</u>	after Dire	ert	4 Homicide determined	building, etc.	Specify,	)	et, lactory,	Onice		20	City or T	own, Sta	ano Nu ate)	mber or Rur	ат ноце ми	m <i>ber</i> ,
	spita ours ours rerel filled	C	29a. Certifier 1 No Certifying Phys	sician: To the best of	my know	viedre death	occurred a	t the time	data and	2022 22	And only 10 And Adv		(-)			
	24 h	edical	(Check only 2 Medical Examination)	ner: On the basis of each manner state	xamınatı	ion and/or inv	estigation,	in my opir	nion, death	occurre	d at the time	e cause e, date a	(s) and ind plac	manner as : e, and due i	stated. to the cause	(s)
	To the Hospital or Attending Physician: The lawithin 24 hours after death. To the Funerel Director: After this certificete hes completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifler	and the state			29c.	License r	number			29d. f	Date sig	ned (Month	Dav. Yearl	
	->-0		m. 012	3 . 4 . 4	^		Property Adam	(D)	11 -	3		-	11	2/~/	/ 1 · • • • • / /	
	0.0		30. Name and address of person who co	moleted cause of day	th (ltor	22a) (Tuna 1	Drine)	14	60	CY		2	//	106	2	
	70		FRENED TO L	TAA ATAA	ui (item	23a) (Type, 1	-nn() <b>-</b> 27	260	111 <	SEU	-117	4 <	7-	7050	=0121	1 4-2
1	Sta	e	31. Date filed (Month, Day, Year)	32. Registrar's	Signati	ure / a	1	ne	0010	CYE	=1416	رر	/ /	7500	ZXXXX	(MD
	Registr		EER 1 5 2006	Margaret A		fassie.	B								217	01

Melvin Myers 06-01070 CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Unpend item# 23a, 27, 28a-f, pende, 9853, 3/29/06 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Melvin Albert Myers February 2006 8:49 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Good Samaritan Hospital Baltimore N/A Months Days Hours Min. 8. Date of Birth Min. 9.20.1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 1. MM 2□F Months 212.30.8106 72 Yrs Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. tnside City Limits or 28a-f ehow Pages 1 and 2 should be filed within 72 hours after death with the Marylai nent of Heatih and Mental Hygiene.

ant: If Item 27 is marked other than "natural", or items 23a or 28a-f ehov ury or other treumatic event, I'm Madical Examinar must be notified at 1 ☐ Yes 2. No **Funeral Director** Parkville MD) Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2808 Clearview Avenue 21234 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1'Mever Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Earl Albert Myers Mildred Unknown ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5411 Hilburn Avenue Baltimore, MD Matthew Myers/nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny Injury or once. Chesapeake Crem. 02.15.06 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation and Funeral Green Pastures Dr. Balto., MD Alternatives 8717 atter 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Head injuries resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, teading to immediate cause. Enter underlying Cause (Disease or injury Examiner Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, δ should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page 2 autopsy de III? Yes Yes Yes 2□ No 2 No or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death / Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ MXYes 2 No 2X5ER/Outpatient 3 □ DOA 28c. Injury at Work? Medical Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred After Division 5 Pending investigation t Natural s after death.

I Director: After din by the fun 1/17/2006 10:30 P 1 ☐ Yes 2 🔀 No 2 XAccident subject fell 3 Suicide 6 Could not be 28e. Ptace of Injury - At home, farm, street, lactory, office building, etc. (Specify) 281 Location (Street and Number or Rural Route Number, City or Town, State) Harford House Bar determined 4 Homicide sidewalk 7509 Harford Rd. Baltimore, MD within 24 hours a To the Funeral Pell To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) OCME noki Februar 13, 2006 pleted se of eath (Item 23a) (Type, Print) 111 Penn Street Baltimore, Maryland 21201

State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month

2006

4s. Facility Name (if not institution, give street and number)  5605 South Marwood 3t, ## 324  10s. Social Security Number  136-38=1051  10s. County of Death  11		For State Registrar  1 Pandent's Name (First Middle Last)		Department of I Certificate of		F	Reg. No. UUD	04322			
1.3. South Security Name (if not institutions, pier stored and number)  5605 South Name (if not institutions, pier stored and number)  5. South Security Number  1.3. Sout		0 100011	n			Month	Day Yes	ar n. n. n			
Social Security Number   Col. Security   Col					or Location of Deat	h		- 1			
136-38-1051   10   200   58   10   10   10   10   10   10   10   1	Į										
Table   Temporary   Temporar		1 DM 25ts		Months Days		(Month, Day	r, Year)	Country)			
Mo. Street and Number   100, 20 Code   20 Code   20 Co					<u></u>	12-20-	1947	New Jersey			
Soot   Marwood   Blvd   #324   20772   USA			,					10d. Inside City Limits			
Secondary Control Black   Secondary   Se			ge Uppe	<del></del>				1 Yes 2 X			
13. Mars Description   12. Was Description of High State   13. Mars Description   13. Mars Description   14. Race American Indian   15. Description   15.							10g. Citizen of What	Country?			
3   Widowed   Devorced   Park Subset   Specify: Black			ecedent Ever in U.S.			pecify Yes or No-		merican Indian			
Security of the property   Technology   Te	-	1 Never Married 2√ Married 1 ∨es	Forces? s 2 1 No	If Yes, specify Cub	an, Mexican, Puert	o Rican, etc.)	ean, etc.) Black, White, etc.				
College (1-4or 5-1)   College (1-4or 5-1)	Ì	If Yes, (	Give 11 r Dates:	1∐ Yes 2 <b>1x</b> No	Specify:		Specify: Black				
Clerk   Federal Government   Free Name (First, Mode, Last)   4   Clerk   Federal Government   17. Father's Name (First, Mode, Last)   4   Clerk   Federal Government   17. Father's Name (First, Mode, Last)   4   Clerk   Federal Government   17. Father's Name (First, Mode, Matter)   18. Mother's Name (First, Mode, Matter)   18. Mode, Matter)   18. Mother's Name (First, Mode, Matter)   18. Mother's Name (First, Mode, Matter)   18. Mother's Name (First, Mode, Matter)   18.	eted			(Give kind of work done)	during most of wor	16b. Kind of Business/Industry					
17. Fasher's Name (First, Middle, Last)		Elementary/Secondary (0-12) College	-		d)		T-11 (	7			
(Unavailable)  Brown  19a. Mailing Address (Sineal and Variety or Rural House Number, City or Town, State, Zip Code)  James McCullough/husband  5605 Marwood Blvd #342 Upper Marlboro MD 20772  20a. Method of Disposition  1 Blurial 2 Commission 3 Removal from State and Disposition (Partie of Code)  1 Blurial 2 Commission 3 Removal from State and Disposition (Partie of Code)  1 Blurial 2 Commission 3 Removal from State and Disposition (Partie of Code)  1 Blurial 2 Commission 3 Removal from State and Disposition (Partie of Code)  21 Signature of Luperis Sproje Lignages  1 Mo 372  22 Name and Agency Frailing & Cremation Service  23 Parti. Erret had disease, or completions that actuated the death. Do not enter the mode of drying, such as cardiac or respiratory or drying, such as cardiac or respiratory or drying, such as cardiac or respiratory or such as a consequence of):  24 Death of the Partie of Disposition (Partie of Code)  25 Sequentially list conditions, Sequentially list condition				CTELK	18. Mother's Nar	ne (First, Middle		overment			
19b. Informant's Name-Relationship (Type, Print)  James McCullough/husband  5005 Marwood Blvd #342 Upper Marlboro MD 20772  20b. Method of Bopostein (Name of Depostein (Name of Depostein (Name of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Comercial Control of Con			Dwar	Tro.		, -,	,	availabla)			
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Common   C		James McCullough/husban	nd	5605 Marwood	Blvd #34	42 Upper	Mar1boro	MD 20772			
21. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature at Experis Sancies Userses  MOSR2 22. Signature and Address of Facility Rapp Furneral & Cremation Service  933 Gist Av Silver Spring MD 20910  Approximate  Approximate  Approximate  Approximate  Approximate  Approximate  Approximate  Approximate  Interval Belower Consideration  Interval	1	_ '_	ceme	of Disposition (Name of tery, crematory or other pla	ce)	Date	20c. Location - City	or Town, State			
33. Gist Av Silver Sprine MD 20910  Approximate mode of cause (Final disease, or complications that acused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, interesting in death)  Book, or heart failure. List only one cause on each line.  Bread ST CARC (NOR)  Due to (or as a consequence of):  Cardinated events resulting in death)  Due to (or as a consequence of):  Due to (or as a			m State		·	-12-2006	Beltsvi]	lle MD			
25. Was case referred to medical examiner?   26. Place of Death (Check only one)   27. Was an autopsy performer?   1   Yes   2   No   No   No   No   No   No   No		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
BLLFTERM VLEY PM ETFUSIONS  1   Yes   2   No   3   Probably 4   Unknown    24a. Was an autopsy performed?   1   Yes   2   No    25. Was case referred to medical examiner?   1   Yes   2   No    25. Was case referred to medical examiner?   1   Yes   2   No    26. Place of Death (Check only one)  1   Yes   2   No    27. Manner of Death   28a. Date of Injury (Month, Day Year)   28b. Time of Injury at Work?   1   Yes   2   No    28a. Date of Injury At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number. City or Town, State)  29a. Certifier (Check only one)   28f. Location (Street and Number or Rural Route Number.    29b. Signature and title of certifier   29c. License number   29d. Date signed (Month, Day, Year)   29d. Date signed (Month, Day, Ye			to (or as a consequenc	e of):							
24a. Was an autopsy performed? 1   Yes 2   No   25b. Was case referred to medical examiner? 1   Yes 2   No   26c. Place of Death (Check only one)   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2   No   1   Yes 2		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 25 No	outcome of pregnancy a birth 2 ☐ Fetal dea gnant at time of death	ith 3 □Ectopic pregnanc	,						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#PI,23b-c, PII,25,27,28a-f, pemF,0853,3/30/06 TT State of Maryland Department of Health and Mental Hygiene [] [6] 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** 4:15 Pm Mckou February 07 2006 JOANNE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Sayview Medical Johns Harkins
5. Social Security Number Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign Months | Days | Hours | Min. | April | 25, 1949North | Carolina Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2∰F Yrs. 237-84-2118 56 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County **ehow** r than "natural", or Items 23a or 28a-f ehov The Madical Examinar must be notified at 1 ☐ Yes 2 🔯 No Director **ESSEX** BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 1243 S. MARLYN AVE death Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "natural; or Item eny Injury or other traumatic event, the Medical Examine 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 XMarried 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: þ BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) FOOD SERVICES CASHIER 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be KATHERINE PRINCE WALLACE JOHNSON ဂ္ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BALTO., MD 21221 KURTIA A. MCKOY/DAUGHTER 1243 S. MARLYN AVE. 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State A/to: 1 4 ☐ Donation 5 ☐ Other (Specify) Mark 21. Signature of Funeral Serling Licens 22. Name and Address of Facility William C. Brown COmmunity Funeral Home P.A. 1206 W. North Ave. Balto., MD 21217 keenen Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Seps-5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events attending physician and for use as the burial-transit The law requires that the death certificate be executed Exami Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown should I assegra 24a. Was an autopsy performs 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Same decistitus this certificete hes 2 N 1 🗌 Yes Arteriosclerotic cardiovascular disease; diabetes Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA

28a. Date of Injury (Month, Day Year)

28b. Time of Injury 28c. Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Wes 25 No 2 28d. Describe how injury occurred Driver of auto 28c. Injury at Work? 27. Manner of Death Certification: After 1 Avaiurai 2 Accident 5 Pending investigation 1 Yes 2 No involved in collision death. 11:29P June 25, 2005 Director: 3 🗌 Suicide 6 Could not be determined 281. Location (Street and Number of Rural Route Number, City or Town, State) Hyde Park Road and Rt. 702, Essex, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide street within 24 hours at To the Funeral D completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 10 MD February 7, 2006 P19640 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lawing Zhu Johns Hopkins Baywen Medical Center, 4940 Eastern Avenue Bultmore, MD 21224 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 5 2006 Registrar

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			-	For State Registrar	State 0	iviaiyia		rtificate of			Reg. No. 006	04324
				Decedent's Name (First, Middle, I	Last)					2. Date of Dea	th Day O Yea	3. Time of Death
•	//	ysiciar Medica camine	1	Catherine Ann 4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of Death	Febru		06 1912 M
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ले		neral			.Sex 1 ☐ M <b>2√</b> ☐ F		rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State or Foreign Country)
5	50 B	ctor		209-22-3544 Usual Residence of Decedent			75 '''			Dec. 2	7, 1930 Pe	ennsylvania
	arylan ehow	ia ia		10a. State 10b. County		10c. (	City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	the Marylar 28a-f ehow	alliton	2129	Maryland Harfor	:d		Churchy	7ille 10f. Zip Code		1	10g. Citîzen of What	
9	1215-0036 within 72 hours after death with the Maryland ene.	oliner must be notified	2	203 Rhineforte	Drive			21028	}		USA	
0	r deat	SECTION .	Tue.	11. Marital Status	12. Was Dece Armed Fo	dent Ever in	U.S. 13.	Was Decedent of H	Hispanic Origin? (Spe an, Mexican, Puerto F	offy Yes or No- lican, etc.)		merican Indian, /hite, etc.
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2/8/06	15-0036 72 hours after death with "nature!", or Hems 23a or	ical E	i e	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation during most of working	10	16b. Kind of Busine	White ess/industry
	21215 ad within 7 /giene.	e Mad	Completed	(Specify only highest of Elementary/Secondary (0-12)	College (1	-4or 5+)	life.	DO NOT use retire	d)	9		
	d 21	ant, th		12 17. Father's Name (First, Middle, La	st)		Acco	untant	18. Mother's Name	(First, Middle,		Accounting
	ld be dental	tic even	0	Raymond A	. Cha	pman			Margaret	L		Bowers
	Maryland d 2 should be file th and Mental Hy	auma		19a. Informant's Name/Relationship			19b. Maili	ng Address (Street	and Number or Rural			
	e land	other traumatic event, the Madical Examiner must be notified at	-	Gregory R. Muolo  20a. Method of Disposition	/ Son	20b			Drive, Eel	Air, N	Jaryland 2 20c. Location - City	
37	Pages nent of Intr. if its	y or o		Burial 2 □ Cremation 3     Donation 5 □ Other (Special Control C		olale		sition (Name of matory or other place	Grans. 2-	13-06		
30437	Baltimore, permit. Pages 1 a Department of Heimportant: if item	y injury ce.		21. Signature of Juneral Sofvice Lie		1	el Air	Name and Addre	Grans. 2 Funeral Ho	me D 7	DEL ALL,	Maryraid
Ŏ	<b>a</b> 88 <b>E</b>	eny i		Markel	( Eng	1		1317 Coke	esbury Roa	d. Abir	nadon. Mar	yland 21009
40		ш		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final	mplications that only by one cause on e	used the de ich line.	eath. Do not ent	er the mode of dyir	ng, such as cardiac or	respiratory arr	rest,	Approximate Interval Between Onset and Death
	Physic /Med			disease or condition resulting in death)	a. Ade		equence of):	teasy .	dustres	5 90	paron	2
7	Exam	iner		Conventially list conditions	, 5e	ver	e 5	PASIC			<b>.</b>	
5	Pg.	sit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (	or as a cons	equence ot):	C				
4	760, C. le be executed sicien and	ial-transit	Yall	that initiated events resulting in death) Last	c. Ue to (	or as a cons	equence of):	1100				
1	760 te be e	ing e			d.							
20	ox 68 certificat	for use as the	- 20	IF FEMALE:								
1	Box eath cer	letached for use as the	lali	23b. Was decedent pregnant in the past 12 months?		come of preg inth 2 ☐ Fe ant at time of	etal death 3	Ectopic pregnancy Other (specify)	у		23d. Date of Month	delivery Day Year
3	O.O.	detached	l ya	1 ☐ Yes 2 █ No 9 ☐ Unknown	9□ Unkno							
fE	S, F es tha	be det		Part II. Other significant conditions	contributing to de	ath but not r	esulting in the u	nderlying cause giv	ven in Part I.			e to the cause of death?
F	ecord law requir as been si	should		1 MAUNIT	, ole	rice	ے جب	1		1 🗆 Y		Probably 4 Unknown
E	~ 0 =	CI C	1	Rheumato	dd U	the c	) alis	<i>dase</i>		24a. Was a autops perfor	sy prior i med? death	
$\bigcirc$		director, page	D	25. Was case referred to medical	aluni	4254	700		26. Place of Death		CONTRACTOR OF THE PARTY OF THE	∕es 2□ No
0	of Vita Physicien: rthis certific		0	examiner? 1  Yes 2  Oo	-		☐ ER/Outpatier		4   Nursing non		ence 6 Other (S	pecify)
7	ding After	funeral	5	27. Manner of Death  1 SNatural 5 ☐ Pending 2 ☐ Accident investigat		if Injury h, <i>Day</i> Year)	28b. Time of Injury	Wor	ryat 2 rk? ]Yes 2 □ No	8d. Describe h	ow injury occurred	
7	Division or Attending after death.	ed in by the funera	2	2 Accident investigat 3 Suicide 6 Could not 4 Homicide determine	be 28e. Place			eet, factory, office		8f. Location (S. City or Town	treet and Number or	Rural Route Number,
Z	Division results	ni bel		4   Homicide	Duliqir	ig, etc. (Spe	спу)			City of Town	n, State)	
	DIVI To the Hospital or At within 24 hours after or To the Funerel Direct	completely filled	alcal	29a. Certifier 1 Certifying 1 Certifying 2 Medical Ex	Physician: To the aminer: On the ba and mann	sis of exami	newladge, daat nation and/or in	onnumed at the tirvestigation, in my o	ms, date and stade, a opinion, death occurre	nd due to the d d at the time, d	aust(s) and mannur late and place, and c	as stated due to the cause(s)
	To the within	Mar		29b. Signature and title of certifier	a.a mgn			29c. Licens	se number	2	29d. Date signed (Mo	onth, Day, Year)
	)	/		1 office	S hom	gm	-MI	Doc	05356	8 5	ebruary	3, 2006
	2	5		30. Name and address of person vo	o completed caus	e of eath (It	em 23a) (Type.	Print) FOO I	upper Ch	man	Ve ACA	W dramo
	1.45.45	State		31. Date filed (Month_Day, Year)	32 R	egistrar's Sig	nature	5	reper Cil	super	HE WILL	21014
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			For State Registrar	State of Maryla		artment of H			giene	04325
	* * *	4	1. Decedent's Name (First, Middle	e, Last)		-		2. Date of Dea		3. Time of Death
	Physici		∆1ma	Mav	McGu	ire		Month Februa:		6 22:00PM
-	/Medic Examin		4a. Facility Name (If not institution				r Location of Death	100144	4c. County of	
	Lxamiji			yland Hospital		Cli	nton		Prin	ce George's
-	Funeral		5. Social Security Number	6. Sex 7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	h	9 Birtholace (State or Foreign
	Director		216-16-0231	1□M 2□XF 88	Yrs.	Months Days	Hours Min.	July I	1,1917	Virginia
	D		Usual Residence of Decedent							
	how		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits 1 ☐ Yes 2 📉 No
	e Ma	cto	Maryland Prince	e George's	Dis	strict He	ights			
	th th	lre	10e. Street and Number			10f. Zip Code			10g. Citizen of W	
	th wi	Completed by Funeral Director	2901 East Avenu	ie		20747			U.S.A	•
	dea	ner	11. Marital Status	12. Was Decedent Ever in	U.S. 13.	Was Decedent of Hilf Yes, specify Cuba	ispanic Origin? (Sp an. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race Black	- American Indian, , White, etc.
9	or It	F.	1 Never Married 2 Marr	II Van Chia		1 ☐ Yes 2 No	Specify:			White
8	ours iral';	d b	3 A Widowed 4 □ Divorced	Year or Dates:						
ις.	72 h	ete		t's Education st grade completed)	(Give	dent's Usual Occup	during most of work	ing	16b. Kind of Bus	iness/Industry
7	hen.	ш	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		<i>DO NOT use retired</i> Iomemaker	1)		Home	
Š	led v tygie her t	ပိ	17. Father's Name (First, Middle,	( ant)	1	lomemaker	18. Mother's Name	e /First Middle		<u> </u>
and	be fi	Be	Charles L. H				Rebecca		Waller Surrame	,
3	ould Merke	To			105 14-10	411 (04			- Church Town 6	State To Code)
ā	l 2 st and r	6	19a. Informant's Name/Relations Charles McGui	ire (Son)		ng Address (Street a				
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23e or 28e-f ehow empt filety or other traumatic event, I'm Madical Examinator must be notified at once.		20a. Method of Disposition	200	Place of Dispo	seition (Name of		-	, ,	City or Town, State
Baltimore, Maryland 21215-0036	if of the later or of or of		1. Burial 2 ☐ Cremation	3 □Removal from State □	cemetery, cre	matory or other place tion Ceme	Feb.			n, Maryland
.≣	tmer tant tant		4 Donation 5 Other (S	респу)			20			
<u>a</u>	permit Depar Impor Impor Pny In		21. Signature of Funeral Service	Licensee Mail // /		2. Name and Addres				
_	40 = 0		you							inton, MD20735
1			23a. Part1. Enter the disease, or spock, or heart failure. List	complications that caused the de only one cause on each line.	ath. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	- Pneu	mol	1 ( 2				0.130( 4.1.0 204.11
	/Medical Examiner		resulting in death)	Due to (or as a cons						
e e	Carrier	_	Sequentially list conditions,	b						
T	Sit 9d	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
	and tran	Examiner	that initiated events resulting in death) Last	c	equence of:					
760,	ate be executed thy sician and the burial-transit	E	,	Due to (or as a cons	equerice or).					
87	cate I	dical		d						
9 X	eath certifica attending pl	Physiclan/Med	IF FEMALE:	23c. If yes, outcome of preg	nancy.				22121	4.1.6
Вох	ath c	an	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnancy			23d. Date Mont	of delivery th Day Year
o.	the the	ysic	1 ☐ Yes 2 🖾 No 9 ☐ Unknown	4☐Pregnant at time o	i death 5	Other (specify)				
٥.	res that the de signed by the a be detached f	듭	Part II. Other significant condition	ons contributing to death but not r	esulting in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contril	bute to the cause of death?
Records,	sign d be	i by	divenic of	ctructive Pic	Imon	J - 15	15656	ړ ا ا م	′es 2 □ No 3	3 Probably 4 Minknown
0	w require been si should b	Completed	1	1		7 3	1300			
Sec.	e law has b	du	Chronic	Leukemi	2			24a. Was autop	an 24b. W sy pr med?/ de	/ere autopsy findings available rior to completion of cause of eath?
<u> </u>	ysician: The is certificate hidirector, page	S	ArTeriscoler	INTIC CERdio	225 U	ular D	1150254		2 No 1	Yes 2 No
ŽĮ.	ician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	Hospital:	/	! Oth	26. Place of Deat			
o	Phys this al dir	٦	1 Yes 2 No	1 inpatient 2	Proutpatie		4   14u13i1g 11c		lence 6 Other	
Ĕ	ding I	o	27. Manner of Death 1 ☑Natural 5 ☐ Pendin		28b. Time o Injury	Worl	yai k? Yes 2 □ No	Zod. Describe ii	low injury occurre	d
<u>s</u>	ttend death tor: the	cat	2 Accident investig	not be	homo form et		163 2 100	28f Location (S	Street and Numbe	r or Rural Route Number,
Division of Vital	after deat Director:	Certification:	4 ☐ Homicide determ	ined 28e. Place of Injury - At building, etc. (Spe	city)	eet, factory, office	}	City or Tow	n, State)	TOT TUTAL TOUTE NUMBER,
_	Hospital	ŭ	29a. Certifier 1 Certifyin	ng Physician: To the best of my k	nowledge dest	h accurred at the tre	ne date and place	and due to the	causals) and man	nnar as stated
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	edical		Examiner: On the basis of examinand manner stated.						
	To the within 2 To the complet	Me	29b. Signature and title of certifie			29c. License	e number		29d. Date signed	(Month, Day, Year)
	F ≯ F ŏ		13+	11		DI	9880	4	Feb. 8	- O /-
	./		30 Name and address of across	who completed cause of death (it	om 22a) /Tun-		100	(	101.0	0 0
	10		50. Name and address of person	T. II	(Type,		outhern	Aun	(1)	C 20032
	Sta	to	31. Date filed (Month, Day, Year)	62. Registrar's Sig	nature	4 J )	Dallicky	Hos	2-1	, - 20032
*	Registr	-344	FEB 1			made				
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		-	For State Registrar	State of Maryland		rtment of He tificate of D			ene 0 0 6	04326
			Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		SOPHIE MARTIN	IEZ					2,2006	4:00 p <sup>M</sup>
	Examin	er	4a. Fecility Name (If not institution, give str			4b. City, Town, or I			4c. County of Deat	
			ANNE ARUNDEL ME 5. Social Security Number 6. Sex	FDICAL CENTI 7. Age (In yrs. Ia		AND If Under 1 Year	NAPOLIS If Under 24 Hrs.	8. Date of Birth	ANNE AR	hplece (State or Foreign
	Funeral Director			M 2₹ 9:		Months Days	Hours Min.	(Month, Day, JUNE 1	Year) Co 5,1913	untry) SPAIN
	D		Usual Residence of Decedent	100 650	Town or Lo					10d. Inside City Limits
	arylar ehow	_	10a. State 10b. County							1 ☐ Yes 2 XNo
	28a-f	Director	MD. ANNE AF	KONDEL (	CROFT	10f. Zip Code		10	g. Citizen of What Co	untry?
	3a or			STREET			1114		U.S.A	
	hours after death with the Maryland tural; or Itema 23a or 28a-f ahow al Examinat must be notified at	Funeral		2. Was Decedent Ever in U.S Armed Forces?	S. 13. V	Vas Decedent of His Yes, specify Cubar		ecify Yes or No-	14. Race - Ame Black, Whit	rican Indian,
٥	after or ite		1 Never Married 2 Married	1 ☐ Yes 2 🕅 No If Yes, Give		Yes 2□ No			Specify:	
0030	ural',	d by	3 Widowed 4 □Divorced	Year or Dates:		an.	SPAN		6b. Kind of Business	HITE
-012	within 72 ene. then "net	iete	15. Decedent's Educa (Specify only highest grade	completed)	(Give	ent's Usual Occupa kind of work done di OO NOT use retired)	uring most of work		bb. Kind of business	industry
717	within hiere.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	НО	USEWIFE			DOMEST	IC
<u> </u>	be filed within 72 hours after death with the Marylar tall Hygliene. de other than "natural", or liems 23s or 28s-f show other than "natural", or liems 23s or 28s-f show event, the Medical Exam har must be notified at	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	laiden Sumame)	
yland		오	MANUEL ALONSO	JUSTO			SOFIA	RODRI		RCIA
Jar	and rand		19a. Informant's Name/Relationship (Type						City or Town, State, .	04444
o,	s 1 and 2 should if Health and Mer item 27 is marke other traumatic		JOSEPH MARTINEZ,  20a. Method of Disposition	20b. Pl	ace of Dispo	FARNBOE sition (Name of			Oc. Location - City or	21114 Town, State
D D	M O		1 X Burial 2 ☐ Cremation 3 ☐ Re '4 ☐ Donation 5 ☐ Other (Specify)	moval from State	•	natory or other place N CEMETI	1	R/06 1	D X T TT M ( D )	E, MARYLAND
Baltimore,	permit. Page Department ( Important: ff eny injury or once.		21. Signature of Funeral Service Licensed		22	Name and Address	s of Facility			
ñ	Ped Fina		Contraction of	a hour	\frac{1}{2}	got Easi	ternegvi	NOE, BA	NERAL HOLLTIMORE,	MD. 21231
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only one	ations that caused the death cause on each line.	. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Physician		tmmediate Cause (Final disease or condition	Ashiration	PNU	mona				Onsot and Boarn
	/Medical Examiner		resulting in death)	Due to (or as a consequ						
7	100	- G	Sequentially list conditions, is any, leading to immediate	Due to (or as a consequ	ianoa offi:					
/	uted d ansit	Examiner	any, Jacong to immediate cause. Enter Underlying Cause (Disease or injury that initiated events							
o`	an an	Еха	resulting in death) Last	Due to (or as a consequ	ence of):					Y.
8760	cate be executed physician and the burial-transit	dicai	d.							
9		a a	IF FEMALE:	to If you outcome of program	200				20d D-11 d-	F
Вох	death certifi e attending od for use as	Physician/M	in the past 12 months?	6c. If yes, outcome of pregnal 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	Day Year
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ر ت	The law requires that the tte has been signed by the bage 2 should be detache	by Pł	Part II. Other significant conditions cont	tributing to death but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribute t	o the cause of death?
Records,	w requires that s been signed t should be deti							1 □ Ye	s 2 100 3□P	robably 4 Dunknown
ဝ၁	e law re has be ge 2 sho	Completed						24a. Was ar	y prior to	utopsy findings available completion of cause of
<u> </u>		Com						perform 1 ☐ Yes 2	ned? death? De No 1 ☐ Ye	2 No
Vita	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	ar	th (Check only one		
Division of Vital	this al di	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Injury	ER/Outpatier 28b. Time of	it 3 DOA	4 Nursing H	ome 5 ☐ Reside 28d. Describe ho	nce 6 Other (Spewinjury occurred	ecify)
O	th. : After the function	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		<br Yes 2 □ No			
N N	or Attendiater death.  Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location (Str City or Town	reet and Number or F	ural Route Number,
	Ital or rs afte raf Diu led in	Cer		Benefit, etc. (epoch)				are to		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely tilled in by the	edical		ician: To the best of my knower: On the basis of examinal and manner stated.						
	To the Mithin To the Comple	Me	29b. Signature and title of certific			29c. License	e number	29	9d. Date signed (Mon	th, Day, Year)
	. >= 0		· WAAA			D 38	8958	e de	2/13/06	
	5		30. Name and address of person who cor	mpleted cause of death (Item	9 6		0 01		-	
	2		Da Get Singh S 31. Date fled (Month, Day (Year)	32. Registrar's Signa		19hway -	sw ole	u Burnu	e MD 21	061
	St: Regist	ate rar	31. Date fled (Month, Day (Year) FEB 1 5 21	006	A A	Service B				

								of Health and	-	aiene	
				1 - State Registrar				of Death		Reg. No. 006	04327
	di di	Physici /Medic		1. Decedent's Name (First, Middle, Last, Helen Elizabeth Ma					2. Date of De	Day Year	
		Examir		4a. Facility Name (If not institution, give				wn, or Location of Deat	h	U <sub>4c.</sub> County of Dea	
	- 1	Funeral	1683 A	Upper Chesapeake No. Social Security Number 6. Sec.	7. Age	(In yrs. last birthday			8. Date of Bir	th Q Bi	rthplace (State or Foreign country)
		Director		220-12-6578	]м жД ғ   80	Yrs.	Months	Days Hours Mill.	Aug. 17	, 1925 Ma	ryland
		ryland how		10a. State 10b. County		10c. City, Town or I					10d. Inside City Limits
		he Ma	Director	Md. Harford	i	Fal	1ston				1 ☐ Yes 2 Ϊ No
		permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natursi", or items 23e or 28e-f show says fujury or other traumatic event, it a Medical Exaction Lead for retified at ance.		10e. Street and Number 2410 Stoneybrook	Road		10f. Zip Ci	21047		10g. Citizen of What C	Country?
in		tems 2	by Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Deceden	nt of Hispanic Origin? (S Cuban, Mexican, Puer	Specify Yes or No to Rican, etc.)	- 14. Race - Arr Black, Wh	
15	920	urs afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ N If Yes, Give Year or Dates:	0	1 □ Yes 2 ⊑	No Specify:		Specify: W	
8	5-0	72 ho natur	Completed	15. Decedent's Edu (Specify only highest grad		16a. Dec (Giv	edent's Usual (	Occupation done during most of wo retired)	rkıng	16b. Kind of Busines	s/industry
0	121	within iene. then	dmo	Elementary/Secondary (0-12)	College (1-4or 5-	4-)	nemaker	retired)		own ho	ome
	nd	al Hyg f other	BeC	12 years 17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle,	Maiden Sumame) t Uttenreit	her
	Maryland	d Meni d Meni marks matics	2	John H. Naumann  19a. Informant's Name/Relationship (Ty	roo Print)	10h Mai	ion Address /S	Street and Number or Ri			
0	S	alth an 27 is i		Dolores Evans/sis			-	ain View Ci			
1/6	Baltimore,	ges 1 a t of He If item or othe		20a. Method of Disposition  1 XBurial 2 Cremation 3 F	Removal from State	20b. Place of Disp cemetery, cri	osition (Name ematory or othe	of er place)	Date	20c. Location - City o	r Town, State
00	Itim	artmen ortant: Injury		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licens		Bel Air			-	Bel Air, N	
9	Ba	Depa Impo		1- Tell	11/			Address of Facility nek Funeral MacPhail I			
-	2			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do not er	nter the mode of	of dying, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
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	) a M	Examiner		Sequentially list conditions	0	. 551.354451105 51).					,
00	J	peti nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):					
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0	Вох 6	The law requires that the death centificat te has been signed by the ettending phy tage 2 should be detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of					23d. Date of de	elivery
#		e death the ette	sicla	in the past 12 months? 1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at 1 9 ☐ Unknown		□Ectopic preg □ Other (spec			Month	Day Year
	, P.O	es that the de igned by the E be detached f	y Phy	Part II. Other significant conditions con	ntributing to death bu	t not resulting in the	underlying cau:	se given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
14elen	ords,	w requires been signs should be	ted by	CAD	asle	operon	<u>,</u>		1 🗆 '	Yes 2 No 3□F	Probably 4 []Unknown
4	Record	has be	Completed			V			24a. Was autop	psy prior to	autopsy findings available completion of cause of
-	Vital F	ician: The certificate rector, pag	e Cor	25. Was case referred to medical				Pi 10	1 Tyes	/	s 2 No
72		Physician: r this certifica ral director, p	To B	examiner?	lospital: Inpatier	nt 2 ER/Outpatie	ent 3 DOA		ath <i>Check</i> o <i>nly</i> d	one) dence 6 ⊟Other (Sp	ecify)
7	on of	ding Physician: The In. After this certificate ha funeral director, page		27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y 28b. Time Year) Injury		. Injury at Work?		how injury occurred	
56	Division	Attend r death sctor:	Certification;	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, farm, s	M treet, factory, o	1 Yes 2 No		Street and Number or F	Rural Route Number,
naschK	Ö	Ital or rs after ral Dira led in b		4 Thomasae	building, etc	. (Specify)			City or To	wn, State)	
$\geq$		To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely lilled in by the funer	edical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and/or i	th occurred at nvestigation, in	the time, date and place my opinion, death occu	e, and due to the urred at the time,	cause(s) and manner a date and place, and du	as stated. re to the cause(s)
_		To the within To the comple	Me	29b. Signature and title of certifier			29c. L	icense number		29d. Date signed (Mor	
					ND		D	006322	0	2/14/200	6
		10		30. Name and address of person who co	empleted cause of de	eath (Item 23a) (Type	BE	LAIR,	MD3	21014	
		Sta Regist		31. Date filed (Month, Day, Year) FFB 1 5 20		r's Signature	2346				

y now.	1	For State Registrar	State of Maryland	/ Depa		lealth and	Mental Hy	giene Reg. No. U	06	04328
Physiciar /Medica	1  -	1. Decedent's Name (First, Middle, Last  Dorothy C. McCa  la. Facility Name (If not institution, give	rthy		4b. City, Town, or	Location of Dea	2. Date of Dea Month Februar	Day	Year 2006 nty of Death	3. Time of Death 2:45P
Examine Funeral Director		10 Harden Ave. 5. Social Security Number 6. Se 10 220-24-0213		t birthday) Yrs.		gs Mills	s. 8. Date of Birt	Ba h y, Year)	1timo	
s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Itams 23a or 28s-1 show other traumatic event, the Medical Examiner must be notified at	CIOL	Usual Residence of Decedent	nore On		Mills 10f. Zip Code	17		10g. Citizen	of What Cou	10d. Inside City Limits 1 □ Yes 2 ☒ No untry?
hours after deal	<u> </u>	11. Marital Status 1 □ Never Married 2 □ Married 3 □ ▼Widowed 4 □ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 X No	ispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)	- 14. F E Spe	Race - Amer Black, White ecify: Wh	ite
led within 72 hours all lygiene. her then "neturel; or it, the Medical Exam.	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	(a completed)  College (1-4or 5+)	(Give life.	dent's Usual Occup kind of work done DO NOT use retired Secreta	during most of w d) ary			factu	
d 2 should be filed th and Mental Hygis 77 is marked other traumatic event, II	10 26	17. Father's Name (First, Middle, Last) William W. Gerbic  19a. Informant's Name/Relationship (7)		19b. Marii	ng Address (Street	Dorot	ame (First, Middle, hy Carli: Rural Route Numbe	s1e		ip Code)
permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra		Jacquelyn A. Duva 20a. Method of Disposition 1 © Burial 2 Cremation 3 □	20b. Plac cem	e of Disponentery, crea	Pennington State of The Indian (Name of The In	ce)	Date	20c. Location	on - City or 1	
permit. Pages 1 a Department of Her important: If item any injury or othe		*4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens	Lane	22	w Mem. Pa R. Name and Addre Cline Fund	ss of Facility		4 Reis		e, MD own Road D 21136
Pnysician /Medical	-	23a. Part1. Enter the disease, or compositions, or heart failure. List only of the composition of the condition resulting in death)	lications that caused the death. ne cause on each line. a	nee	er the mode of dyir	100		rrest,		Approximate Interval Between Onset and Death
ysicia ysicia	cal Exa	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence.  Due to (or as a consequence)	nca of)						
The law requires that the death certificate ate has been signed by the attending phys page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnanc 1 Live birth 2 Fetal de 4 Pregnant at time of deal	eath 3	Ectopic pregnancy Other (specify)	/		23d.	Date of deli	very Day Year
he law requires that has been signed be age 2 should be detailed.	ted by PI	Part II. Other significant conditions co	ntributing to death but not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did t			the cause of death?
n: The law i		OS Was assessed to and include					1 ☐ Yes	osy ormed? 200No	prior to death?	topsy findings available completion of cause of
ng Physician: Ti	on: To be	25. Was case referred to medical examiner?  1 ☐ Yes 20 No  27. Manner of Death  1 ☑ Natural 5 ☐ Pending		∛Outpatie 8b. Time o Injury		er: 4 🗀 Nursing	eath (Check only of Home 5 Residue) 28d. Describe	dence 6 🗆		ify)
To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, st		Yes 2 □ No	28f. Location (. City or Tox		umber or Ru	ral Route Number,
he Hospitt in 24 hours he Funera pletely fille	Medical	29a. Certifier  (Check only one)  (Check only one)  (Check only one)	vsician: To the best of my knowledger: On the basis of examination and manner stated.	edge, deat n and/or in	h occurred at the til vestigation, in my o	me, date and pla ppinion, death oc	ce, and due to the curred at the time,	cause(s) and date and pla	I manner as ce, and due	stated. to the cause(s)
To the within 2 To the complet	Σ	29b. Signature and title of certifier	M		29c. Licens	e number		29d. Date sig	•	**
5 State	e	30. Name and address of person who of the state of the st	ompleted cause of death (Item)  32. Registrar's Signatur	S 00	Carto:	ave	Bar	Timo	Ren	M71572

DHMH 17 Rev 1/2001

Wanda J.	Magan
06-01036	
CT	1

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

.036	J	rieas	State of Ma		epartment of h		·=	_	
		1 - For State Registrar	State of Mis	•	Certificate of			g. No. 006	04329
		Decedent's Name (First, Middle,	Last)				2. Date of Death	1	3. Time of Death
Physicia		Wanda J. Magar	1				Februar	y 10 20	
/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, o	or Location of Death		4c. County of Dea	
		Prince George's			Chever				George's
Funeral			5. Sex 7. Age 1 ☐ M 2 ☐ F	e (In yrs. last birti	nday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month Day	Year) 9. Bi	rthplace (State or Foreign country)
Director		206-48-4829 Usual Residence of Decedent	Т Х	39	13.		July8,19	900 Per	nnsylvania
/land		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Man a-f et	ţo	Maryland Prince	Georges	Bowie	2				1 □ Yes 2 X No
or 28	irec	10e. Street and Number		•	10f. Zip Code		10	g. Citizen of What C	ountry?
ath w	by Funeral Director	3406 Morlock Lan			2071			United St	
er der	une	11. Marital Status	12. Was Decedent I Armed Forces?		13. Was Decedent of H If Yes, specify Cubi	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
rs aft	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d t ☐ Yes 2 ☐ N If Yes, Give X Year or Dates:	NO	1 ☐ Yes 2 <b>X</b> ☐ No	Specify:		Specify: V	<i>N</i> hite
2 hou	led	15. Decedent's	Education	16a.	Decedent's Usual Docur	pation	. 1	6b. Kind of Busines:	s/industry
hin 73	pie	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	5+)	(Give kind of work done life. DO NOT use retire	during most of word)	rking		
or the	Completed		4		Registered			Nurse	
be file tal Hy d oth	Be	17. Father's Name (First, Middle, La	ist)				ne (First, Middle, N	faiden Surname)	
ould Men Marke	2	Larry Ward		1		Carol K			
permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Depertment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Iteme 23e or 28e-f ehow empt injury or other treumatic event, the Medical Examination and once.		19a. Informant's Name/Relationship			Mailing Address (Street				
Heelt Heelt Heelt Heelt Heelt		Robert Magan, H	uspand	20b. Place of	06 Morlock Disposition (Name of	I		YIANG ZU/]	
ages ont of t: If lt		1   Burial 2 □ Cremation 3  Donation 5 □ Other (Spe		cemeter	n Memorial		.14.2006	Allentown	ı. PA
nit. Pertme		21. Signature of Funeral Service Li			22. Name and Addre			. Broad S	••••
Depermine Depermine on y ir		> Junoty Ho	W MO111	13	Connell Fu	neral Ho	m 🗘	ehem, PA	
		23a. Part1. Enter the disease, or conshock, or heart failure. List or	omplications that caused	the death. Do n	ot enter the mode of dyir	ng, such as cardiad			Approximate Interval Between
Physician		tmmediate Cause (Final disease or condition	Muld	tiple	Tuin	ies)			Onset and Death
/Medical		resulting in death)	Due to (or as	a consequence o	f):				
Examiner	_	Sequentially list conditions,	b		4)				
19d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence o	п):				
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deeth certificate b attending physical for use es the b									
th cer tendir r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy 2 Fetal death	3 ☐Ectopic pregnanc	y		23d. Date of de	
e dee the at ned fo	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown	t time of death	5 Other (specify)			Month	Day Year
w requires that the deben signed by the should be detached		Part II. Other significant condition	s contributing to death b	out not resulting in	the underlying cause on	van in Part I	23e Did tob	acco use contribute	to the cause of death?
signe d be	d by	, un in a most significant contains	o contributing to double	at the resulting in	and disabilying decise give	VOIT II T UTT 1.			Probably 4 □Unknown
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he lav	E G						autopsy	y prior to ned? death?	completion of cause of
ifficati or, pa	ပိ	25. Was case referred to medical				26 Place of Dec	1 💢 Yes 2 ath (Check only one		s 2 No
ysicie is cer direct	To B	examiner? 1∑Xes 2 □ No	Hospital:	ent 2 ER/Out	patient 3 DOA Ott	200		nce 6 ☐Other (Sp	ecify)
ng Ph ter th		27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Inju (Month, Da	y Year) Ir	ime of 28c. Injury	ry at	28d. Describe ho	4 1 1 1 1 1 1 1 1	eliele
endli eath. or: A the fu	catic	2 Accident investiga 3 Suicide 6 Could no	ition 2 - 9 -	06 23	50 M 10	Yes 2 No	lept road	l, struck	
or Att	Certification:	4 Homicide determin		c. (Specify)	m, street, factory, office		28f. Location (Str City or Town	reet and Number or F State) W/B	Rural Route Number,
pltal		29a. Certifier 1 ☐ Certifying	Physician, To the best		Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	mo data and alass	ratuxent	Icher Rd,	Anapolis MD
To the Hospital or Attending Physicien: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use es the	Medicai		Physician: To the best xaminer: On the basis of and manner sta	f examination and					
ro the	Me	29b. Signature and title of certifier	1	1/1	29c. Licens	se number	25	d. Date signed (Mor	nth, Day, Year)
> 0		> XIC	AUX.	VV	Ω	CME	Fe	ebruary 10	2.006
		30. Name and address of person w	no completed cause of d	death (Item 23a) (		v a Alui	1.0	- NI WILLY IC	, 2000
		S.K. H	JUGAN	$\cup$	111 Pe	enn Stree	t Baltimo	ore, Maryl	and 21201
Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	rar's Signature	A STATE				
riegisti	211	TEDIA	ALLEN CHULL	1 A 1 1	18 18 18 18 18 18 18 18 18 18 18 18 18 1				

Registrar DHMH 17 Rev 1/2001

State Registrar JAK MI

31. Date filed (Month, Day, Year)

FEB 1 5 2006

DHMH 17 Rev 1/2001

32. Registrar's Signature

111 PENN STREET BALTIMORE MARYLAND 21201

State of Maryland / Department of Health and Mental Hygiene 06331 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 11, Day 2006 **Physician** 4:30 P M Jennie J. Mullen /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center Baltimore Towson If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 95 Yrs. 8. Date of Birth January 5, 1911 9. Birthplace (State or Foreign **Funeral** 214-26-8504 1 □ M 2 💢 F Mary Tand Director Usual Residence of Decedent 10a State 10h County 10c. City, Town or Location worle 10d. Inside City Limits other treumatic event, the Mudical Examiner must be notified at Maryland Baltimore Baltimore 1 Yes 2 No Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 238 8620 Kelso Drive Apt. 207 A 21221 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: or iteme 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify White Completed by 3 ☑ Widowed 4 ☐ Divorced "naturel" 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 end 2 should be filed within 7 Department of Heelth and Mental Hygiene. Importent: if them 27 is marked other then "ne eny Injury or other treumatic averages." (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Ciaccio Rosaria Marino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Kresslein/Daughter 5 Candlelight Court Timonium Maryland 21093 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 DBurial 2 □ Cremation 3 □ Removal from State New Cathedral Cemetery 2-17-06 Baltimore Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Christina L. Hilton 27. Name and Address of Facility 5305 Harford Road Baltimore Maryland 21214 hustina 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** artery Coronary /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ending physicien and use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical cete hes been signed by the ettending ( , page 2 should be detached for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths?
1 □ Yes 2 / □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4⊡Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificete 1 Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) 1 ☐ Yes 2 ☐ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injuly occurred After 1 Natural 5 Pending investigation To the Hospital or Attendir within 24 hours efter death. To the Funerel Director: Al 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 13 2006 February

DHMH 17 Rev 1/2001

State Registrar

Africa Cua 31. Date filed (Month, Day, Year)

charles

Lemme

6601 N. Charles St Bannore mg Z1204

and address of person who completed cause of death (Item 23a) (Type, Print)

w

32. Begistrar's Signature

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** GLADYS 1747 PM MARKEL 2006 Februar /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner RANDALIS TOWN

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. BALTIMORE NORTH WEST HOSPITAL 8. Date of Birth (Month, Day, Year) NOV.10,1913 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1 ☐ M 2 ☑ F 92 Yrs. MD Director 217-14-0392 Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f ehow r than "natural", or itame 23a or 28a-f ehov the Medical Examiner must be notified at 1 Yes 2 No Director N7A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6807 PARK HEIGHTS AVENUE #4-A 21215 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ø No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 WHITE 1 ☐ Yes 2 No λ Specify 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "na eny injury or other treumatic event, the Medic once. Elementary/Secondary (0-12) College (1-4or 5+) **SECRETARY EDUCATION** 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be FLINKMAN SEIDMAN NATHAN EVELYN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 GLYNN GARTH - REISTERSTOWN, MD 21136 S.SHERALD SEIDMAN / COUSIN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MIKRO KODESH BETH ISRAEL 2/14/06 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Toca 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dissection minutes aortic disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a cons vuence of Examiner physicien and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? رجي Division of Vital Records, þ certificate has been signi rector, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Linknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 204No 1 Yes 200 No 1 ☐ Yes Hospital or Attending Physician: funeral director 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ⊠ No Inpatient 2 ER/Outpatient 3 DOA After this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a
To the Funeral C
completely filled Medical 29a. Certifier 🕊 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 00059736 mp. 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WA TISH PEBORAH MURTHWEST HOSPITAL 5401 MO COURT 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 5 2008 Registrar

			200	artment of Health and Menta	al Hygiene	04333
			Decedent's Name (First, Middle, Last)		te of Death	3. Time of Death
	Physici /Medio		TYRONE MCCLAIN SR.	FE:	nth Day Ye B12,2006	I P M
i.	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of D	eath
			JOSEPH RICHIE HOSPICE	BALTIMORE	N/A	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days Hours Min. (Mo	onm, Day, Year)	Birthplace (State or Foreign Country)
			Usual Residence of Decedent	AUG	G. 28,1938	MARYLAND
	yland		10a. State 10b. County 10c. City, Town or Le	ocation		10d. Inside City Limits
	e Ma	cto	MD. N/A BALTI	MORE		1 Yes 2 No
	with the Maryland a or 28a-f ehow be notified at	Director	10e, Street and Number	10f. Zip Code	10g. Citizen of Wha	t Country?
	eth w	ra I	4320 FREEDOM WAY APT. 8T	21205	U.S.A.	
	er de	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 ★ Married 1 □ Yes 2 ★ No	Was Decedent of Hispanic Origin? (Specify Ye If Yes, specify Cuban, Mexican, Puerto Rican,		American Indian, Vhite, etc.
5	hours after deeth with the Maryland tural', or Iteme 23a or 28a-f ehow al Examinar must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2 ☐ Yoo Specify:	Specify: B	LACK
ž	a within 72 hours after deeth w jiene. r than "netural", or Iteme 23a the Medical Examinat must		15. Decedent's Education 16a. Dece	dent's Usual Occupation	16b. Kind of Busine	ess/Industry
9500-512	within 72 ene. than "nat	Completed	(Specify only highest grade completed) (Give life.	kind of work done during most of working DO NOT use retired)		,
N	d wit	Б	Omit	BORER	WESTSID	E MATTRESS
and	I be filed ntal Hygi ed other event, I	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (First,	Middle, Maiden Sumame)	
5	Men Men arke	မှ	THOMAS MC CLAIN	DORA GREEN		
Mar	0 4 m m			ng Address (Street and Number or Rural Route		
	s 1 and if Heelth item 27 other to	. 5	ELIZABETH MCCLAIN / WIFE 430  20a. Method of Disposition 20b. Place of Dispo		BALTO, MD. 2	
Ď	0 0		X1 Burial 2 Cremation 3 Removal from State	matory or other place)	20c. Location - City	
Baitimore,			4 Donation 5 Other (Specify) MT. ZIO	N CEMETERY FEB. 16	,2006 BALT	O,MD.
g	permit. Depentimport. any inj		Boundary Alexander	Name and Address of Facility ALVIN B. SCRUGGS F	UNERAL HOM	E
			23a. First, Enter the disease, or complications that caused life distinction on the	412 F. PRESTON ST.	BALTO, MD.	21213 Approximate
	Physician		shock, or heart failure. List only one cause on each line.			Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	adenocareino	ma	Sweek
	Examiner					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	cuted nd ransi	Examiner	that initiated events c.			
Š.	e exe	EX	resulting in death) Last  Due to (or as a consequence of):			
9/8 8/90	requires that the death certificate be executed een signed by the ettending physicien end hould be detached for use as the burial-transit	dical	d			
و ×	leath certifica ettending ph I for use as t	Physician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			
X Q R	etten for us	lan	in the past 12 months?	Ectopic pregnancy	23d. Date of Month	delivery Day Year
j	the d	ysic	1 Yes 2 4 Pregnant at time of death 5 L 9 Unknown 9 Unknown	Other (specify)		
J.	res that the de signed by the e be detached f		Part II. Dther significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I. 23	e. Did tobacco use contribut	e to the cause of death?
rds,	quires n sigr	d by	Diabetes hellitus		1  Yes 2 No 3 □	Probably 4 Dunknown
င္ပ		lete		24	a. Was an 24b. Were	autoney findings available
Vital Record	<b>a</b> + <b>a</b>	Completed			performed? deat	
ē	ician: Th certificate ector, pag	a)	25. Was case referred to medical	26. Place of Death (Chec		Yes 2□ No
	di is	To B	examiner? 1   Yes 2   Hospital: 1   Inpatient 2   ER/Outpatien	100	Residence 6 Other (	Special DSMCO
ם ה	ding Ph h. After th funeral		27. Manner of Death 1 Death 1 Death 28a. Date of Injury (Month, Day Year) Injury		scribe how injury occurred	1007/100
OIS	uttendii death. ctor: A y the fu	catle	2 Accident investigation	M 1 Yes 2 No		
Division	of or Attend efter death Director; / d in by the f	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)		cation (Street and Number or y or Town, State)	r Rural Route Number,
_	urs e eral C					
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  2 ☐ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, and due vestigation, in my opinion, death occurred at th	to the cause(s) and manne e time, date and place, and	r as stated. due to the cause(s)
	To the within 2 To the complet	Me	29b. Signatore and title of certifier	29c. License number	29d. Date signed (M	onth. Dav. Year)
1	F > F 0		JAMMUN MO	D32400	2/1	2106
			30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)	11	1100
			MR. J. A. Haller 600 N	· Wolfe St. 13	actimire	21287
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	M <sup>P</sup> e		
	Registr	ar	FEB 1 5 2006			

DHMH 17 Rev 1/2001

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Month Year Nagaria Ramniklal 16:48 M February 12 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital The Johns Hopkins City Baltimore n/a If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral №** M 2□ F Director 218-19-5214 Jan 22, 1948 58 Kenya Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location r than "naturel", or Iteme 23a or 28e-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 Tyyes 2 □ No Prince George's Maryland Laure1 Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14918 Kalmia Drive 20707 Funeral India 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married Maryland 21215-0036 1 ☐ Yes 🛠 ☐ No Specify: þ 3 Widowed 4 Divorced Asian-Indian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4yr Chemist Paint Company 7 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Heelth and Mental Hem 27 is marked of Ramjibhanji Nagaria Rajubai Lalakia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) If Item 27 i Geetaben R. Nagaria/wife 14918 Kalmia Drive Laurel, Maryland 20707 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 Burial 2 XCremation 3 Removal from State 5 permit. Page Department o Importent: If any njury or once. 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 2/16/2006 Odenton, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. A Doma 6 uanta ( 1411 Annapolis Road Odenton, Maryland 21113 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Myocardial infarction Immediate Cause (Final disease or condition resulting in death) **Physician** H400 /Medical Hypertension arteriosclerotic cardiovascular disease Examiner My o cardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): CERTIFICATION APPROVED BY MEDICAL EXAMINER Box 68760, Physician/Medical use as ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav 4 Pregnant at time of death 5 Other (specify) signed by the e Ö 9 Unknown 9 Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Cholangiocarcinoma; Hepatic artery bleed complicating 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an stent repositioning autopsy performed 1 Yes 2 No of Vital : After this certific funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Monpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 27. Manner of Death 1 Chatoral 2 Accident 28d. Describe how injury occurred **Hepatic** 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: Division s after dea. 5 Pending Feb. 10, 2006 unknown 1 ☐ Yes 2 No artery injury during procedure investigation 6 Could not be determined within 24 hours after de To the Funerel Diracto completely filled in by th 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Royte Number, City or Town, State) **Johns Hopkins Hosp** 600 N. Wolfe St. Balto. Md. 4 Homicide ō hospital Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Scott Berkon HZ, MD RESIDENT RES - 000 February 12, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Scott Bernantz, Johs Hopkins Hospital, 600 North Wolfe Street, Baltimore, Mayland 21287

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

			1 - For State Registrar			nd / Depa		of He	<b>Ensure</b> A ealth and I Death			006	04335
	Physic /Med		Hrank	Victor			rseghi		-	2. Date of De Month Februa	ath	13,2ď86	3. Time of Death 7:15 P м
	Exami		A = 30 At 00	give street and num	iber)				Location of Death			: County of Death	
			1908 Midland Ro	ad				ndall				Baltimore	
	Funeral Director		5. Social Security Number 213–09–1903	6. Sex 7 1 1 M 2 □ F		o. last birthday)  O. Yrs.	If Under 1		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th	0.00	place (State or Foreign
			Usual Residence of Decedeni	21	8	9 115.				(Month, Da March	22,1	1916 Mai	yland
	unylan show	_	10a. State 10b. County		10c. C	ity, Town or Lo	cation						10d. Inside City Limits
	Me Ma	cto	Maryland Balti	more		Dundall	2						1 ☐ Yes 2 📉No
	with t	Funeral Director	10e. Street and Number 1908 Midland Ro	- a			10f. Zip 0				10g. Cit	izen of What Cou	ntry?
	death me 23	era	1300 MIGIANG RO	12. Was Deced	lent Ever in I	18 12 1	Mac Doords	2122			US		
ထ္	or ite	F	1 Never Married 2 Marrie	Armed Ford	es? 2 <b>⊠</b> No	J.S. 13. V	Yes, specif	y Cuban,	panic Origin? (Sp , Mexican, Puerto	Decity Yes or No Dican, etc.)	-	<ol> <li>Race - Ameri Black, White,</li> </ol>	can Indian, etc.
5-0036	72 hours after death with the Maryland Insture!', or Iteme 23a or 286-1 ehow dical Examiner must be nutified at	d by	3	If Yes, Give Year or Dat		1	☐ Yes 2¶	Q No	Specify:			Specify: Whit	e
7	be filed within 72 hours after death with the Marylan Ital Hygiene. Id other then "netural", or iteme 23a or 28e-f enow event, the Madical Examiner must be mutified at	Completed	15. Decedeni's (Specify only highest	Education grade completed)		16a. Deced (Give	ent's Usual kind of work	Occupati done dui	ion ring most of work	una	16b. K	ind of Business/In	dustry
2121	within jiene.	E O	Elementary/Secondary (0-12) 6 years	College (1-	4or 5+)		trol M						
	be filed hal Hygie od other	Bec	17. Father's Name (First, Middle, La	ast)		COII	CTOT I		8. Mother's Nam	e (First, Middle,	Bet	hlehem S	teel
<u>X</u>		10	Napoleon Persegh							randale:		,	
_	2 9 9 9		19a. Informant's Name/Relationshi									r Town, State, Zip	Code)
	1 end Heelth tern 27 other tr		Frances M. Zivko	ovich Daug		1963 ] Place of Dispos	Holbor	n Ro	oad, Dun				
Ē	0 0	-	1 Surial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	Removal from St	ate	cemetery, crem	atory or other	er place)	Febr	uary		ecation - City or To	
Baltimore,	orte		21. Signature of Furieral Service Lie	,,	0.0				1 1 / 1	2006	Bal	timore,	Maryland
מ	Ped Fig.		Enthory	Conne	Ulu	/ S	onnell 110 So	y Fu Iler	nerál Hos	ome Of I	Dund	alk,P.A. alk,Md.	21222
			23a. Part1. Enter the disease or co shock, or heart failure. List or	omplications that cau	sed the deat	th. Do not ente	r the mode o	of dying,	such as cardiac	or respiratory are	est,	ast, na.	Approximate
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	-a HCU	le r	1400	Coon	2	leur	liemia			Onset and Death
	Examiner		1000ming in Godini)	Due to (or	as a conseq		/		, 000				3mom/1)
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to for	as a conseq	uence of):							25 years
/	nd nd transit	Examiner	triat initiated events	. Cor	onan	4 AV	kus	de	11 6.				15000
o O	cien a	EX	resulting in death) Last	Due to (or	as a conseq	uence of):	1						1) 7200
000	within 24 hours efter death.  To the Funerel Director: After this certificate has been signed by the eltending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical		d									
X 3	anding use e	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna	incy							
ם פ	ed for	sicia	in the past 12 months? 1 \( \text{Yes}  2 \( \text{No} \)		t at time of de		ctopic pregr Other (specif				2	3d. Date of delive Month	ry Day Year
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, פרי פרי פרי פרי פרי פרי פרי פרי פרי פרי	signed b	þ	Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the und	lerlying caus	e given ir	n Part I.			se contribute to th	
5	plean sign	Completed								1 🗆 Ye	s 2 2	No 3 Proba	bly 4 Unknown
ם פ	e has	duc						-		24a. Was a autops perform	y	prior to com	sy findings available ipletion of cause of
	is certificate ha	Be C	25. Was case referred to medical							1 ☐ Yes 2	2 100	death? 1 ☐ Yes	2□ No
hveic	this ce al dire	ဂ္	examiner? 1 Yes 2 No	Hospital: 1 fnpa	atient 2 1	ER/Outpatient	3□ DOA	0.4	<ol> <li>Place of Death</li> <li>Nursing Hon</li> </ol>			Other (Specify)	
d out	h. After I funera	0	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of II (Month, I	njury Day Year)	28b. Time of Injury	28c.	Injury at Work?		28d. Describe ho			
The state of the s	death ctor: y the	licat	2 Accident investigate 3 Suicide 6 Could not	he -	(a) a (b)				2 🗆 No				
20	s efter	Certification:	4  Homicide determined	building,	etc. (Specify	me, farm, stree	t, factory, off	ice	2	8f. Location (Str City or Town	eet and , State)	Number or Rural	Route Number,
Osoit	unere unere		29a. Certifier 1 Certifying P	hysician: To the beaminer: On the basis	st of my knov	wledge, death o	ccurred at th	e time, d	date and place, a	nd due to the ca	use(s) a	and manner as ste	tod
the	within 24 hours after of the Funeral Directompletely filled in by	Medical		miner: On the basis and manner	of examinati stated.	ion and/or inves	stigation, in r	ny opinio	on, death occurre	d at the time, da	ite and p	place, and due to	he cause(s)
ů.	₹ 8		29b. Signature and title of certifier	1/MA	)		29c. Lic	ense nu	mber / 2 - 2	29	d. Date	signed (Month, D	ay, Year)
	m	-	30. Name and address of person who	completed as	death (*)	00-1-7	1	44	173		2/	14/06	)
	17	1	Nontre Mi Kak	completed cause of	30 I-	23a) (Type, Pri	9 A	enu	P #	05 Din	. 1 .	Ik Hal	21222
	State	е	31. Date filed (Month, Day, Year) FFB 1 5 2	Regis	trar's Sign					-3 00	ارمو	110, 1100	4144
	Registra	ľ	LEDIA	LO CONTRACTOR	2.80	1							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 4c. County of Death Month John Sylvester Perugino 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Upper Chesapeake Medical Center Bel Air Harford | Months | Days | Hours | Min. | Month, Day, Year) | O1/29/1943 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1**X** M 2 ☐ F 219-60-5422 63 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 ☐ No MD Harkord Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1320 South Tollgate Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Handicapped 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank J. Perugino Elizabeth P. Fisch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roxanne Perugino-Sister 2401 Calvert St., NW, Washington, DC 20008 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) R.A. Ferris & Co. 02/09/06 West Chester. PA 21. Signature of Funeral Service Licensee Mitchell-Smith Funeral Home, P.A. waine " 123 S. Washington, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Assiration Mimaria Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan 1 ☐ Yes 2 1 NO 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Stripatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide

Perugino of Vital Records, P.O. Box 68760,

To the Hospitei or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funarel Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit and property.

**Physician** 

Examiner

**Funeral** 

Director

the Medical Exeminer must be notified at

2 should be f and Mental I is marked of

permit. Pages 1 and 2 sh Department of Health and important: if item 27 is m eny injury or other traum once. Directo

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Completed

Be

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Physician/Medical

by

Be

Certification: To

Medical

29a. Certifier

29b. Signature and title of certifier

/Medical

State Registrar 30. Name and a rress of person who completed cause of death (Item 23a) (Type, Print)

Apurva Desai 500 Upper Chesapa Ke

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

I. Decedent's Name (First, Middle, Last)

**Physician** 

23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Minknown 1 ☐ Yes 2 ☐ No

Month

Day

06337

3. Time of Death

2006 10:30p

Birthplace (State or Foreign Country)

Black

21215

Approximate Interval Between

Onset and Death

Weeks

10d. Inside City Limits

1 ☐ Yes 2 No

MD

Reg. No.

Year

2. Date of Death

Month

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 No

26. Place of eath Check on one Other: 4 Sursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

D52544

2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Geine 121 # 204 Catansville, UD Benjamin S. Lee, MD 100 31. Date filed (Month, Day, Year) FEB 1 5 2006 . Registrar's Signature

3□ DOA

Registrar

Completed

Medical

neimer

5 Pending

investigation 6 Could not be determined

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day Year)

25. Was case referred to medical

29b. Signature and title of certifier

2 10

examiner?

1 Tes

27. Manne Death

1 Pratural

2 Accident

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

DHMH 17 Rev 1/2001

Division of Vital

After

To the Hospital or Attending within 24 hours effer death. To the Funeral Director; Afte completely filled in by the fun

Hospital or Attending

2 ER/Outpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

physician

28b. Time of

			1 - For State Registrar	State of Marylan		rtment <i>tificate</i>			Mental H	ygiene Reg. No	UUb	04338
į,	Physic		Decedent's Name (First, Middle, La:     Hazel Virginia						2. Date of D	eath Day	Year 2001	3. Time of Death
1	/Medi Exami		4a. Facility Name (If not institution, give			4b. City, T	own, or L	ocation of De	path		County of Death	
100	Funeral		5. Social Security Number 6. S	tha Reha!	last birthday)	Per If Under 1		If Under 24 H		lirth	Jar-Ro	pplace (State or Foreign untry)
 Yg	Director		242-14-3813 Usual Residence of Decedent	□M 2 <b>©</b> F 87	Yrs.	Months	Days	Hours M		Day, Year) 14, 1	918 Vir	
	Aaryland I ehow	ō	10a. State 10b. County		y, Town or Loc	ation						10d. Inside City Limits 1 ☐ Yes 2∑No
	28a-	Director	Maryland Harford 10e. Street and Number	В	el Air	10f. Zip (	Code			10g Cit	izen of What Cou	into/?
	With 3a or		410 E. MacPhail	Road		,	21014	1		. og. o.	USA	,
36	within 72 hours after death with the Maryland sine. than "naturel", or iteme 23a or 28e-f ehow ha Madical Examinat ribut 2b rigitified at	by Funerai	11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1  Yes 2 No If Yes, Give Year or Dates:	11	as Decede	ent of Hisp fy Cuban,	panic Origin?	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Amer Black, White	, etc.
21215-0036	I within 72 hour jiene.	Completed t	15. Decedent's Ed (Specify only highest gra	lucation	16a. Decede		k done du	ion ring most of a	working	16b. K	ind of Business/l	Mite ndustry
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р 2	Hyg Tr.		17. Father's Name (First, Middle, Last)		TICHE	THONCI		8. Mother's N	lame (First, Midd			
Maryland	D 2 3 C	To Be	Arlie (nmn)	Senter				Sally	(nmn)	Tiđy		
	47 tra		19a. Informant's Name/Relationship ( Joyce Curry / De						Havre C			ryland 21078
nore	9 to 1 1		20a. Method of Disposition  1 ☑ Buria 2 ☐ Cremation 3 ☐  4 ☐ Donation 8 ☐ Other (Specific	Removal from State	Place of Disposi emetery, cremi	atory or oth	her place)	1	Date		ocation - City or 1	
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature Funded Seque Lie	Isee	<sup>2</sup> M	Name and ICCOM	Address AS FU	neral	3 2-15-06 Home, P.	Α.		
7. 7.	Physician		23a/ Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	h. Do not enter	r the mode	of dying,	such as card		arrest,		and 21009 Approximate Interval Between Onset and Death
8760,	Medical Examiner physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Underfying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseq c. Due to (or as a conseq d.	uence of).							
.O. Box 68	death certific e attending p od for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3 □8	Ectopic pre Other <i>(spe</i>					23d. Date of delim	v <b>ery</b> Day Year
S, D	signed by	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the und	derlying cai	use given	in Part I.				the cause of death?
Vital Record	The law requires that the tite has been signed by the bage 2 should be detache	Completed							24a. We		24b. Were aut	opsy findings available ompletion of cause of
a									1 ☐ Yes	-		2 No
Ĭ	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:			Othan		eath Check only			
ō	Phys ral di	- T	1 ☐ Yes 2 PNo  27. Manner of Death	1 Inpatient 2 2	ER/Outpatient 28b. Time of		c. Injury a	4.2 TAUISING	Home 5 Re			ify)
Division	Attending I or death. ector: After by the funer	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Day Year)	Injury	М	Work? 1 □ Ye	s 2 □ No				
Divi	F F C	Certif	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, stre	et, factory,	office		City or T	(Street ar. own, State	id Number or Rui a)	ral Route Number,
	To the Hospital of within 24 hours af To the Funeral D completely filled in	edicai	29a. Certifier Certifying Ph (Check only 2 Medical Examone)	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wiedge, death tion and/or inve	occurred a estigation, i	t the time in my opir	, date and pla nion, death o	ace, and due to the courred at the time	e cause(s) e, date and	) and manner as d place, and due	stated. to the cause(s)
)	To the vithing To the comp	Me	29b. Signature and title of certifier	chomoly	nno.		DO		5		te signed (Month	
	6		30. Name and address of person who	completed cause of death (Item	1 23a) (Type, P	Print)	PI	25	N. MA	W.	Q 3EZ	714,2006 MD 2104
100	St. Regist	100	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	. 1						

Hazel Mipps

AMEND TTEM 5 PEFFICES 8/25/06 and Mental Hygiene | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** February 10, 2006 1:00 P Howard Elmer Preston /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Timonium <u>Stella Maris Hospice</u> Social Security Number 220–24–8883 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**∑**M 2□F Yrs. Director 75 Maryland Nov. 27, 1930 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f ehow the Madical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Harford Edgewood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21040 U. S. A. 342 Winterberry Drive Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced 'natural' White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 8th Grade Steel Fabricator Steel jes 1 end 2 should be filed v of Heelth and Mental Hygie If item 27 is marked other t or other traumatic event, th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Scott Preston Madeline Bowen . 1 end 2 s.
...t of Heelth and h.
...tant: If item 27 is r.
ny injury or other? 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendie Preston (Wife) 342 Winterberry Dr., Edgewood, Maryland 21040 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Depertment of H.
important: If ites
eny injury or oth 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oaklawn Cemetery 02/14/2006 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySchimunek Funeral Home of Bel Air 610 W. Macphail Rd., Bel Air, Md. 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) PARKINSON'S DISEASE Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of). Examiner Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Š 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death Check only one Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No. investigation Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide after within 24 hours a To the Funerel C 10 Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and crannel as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cai 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2/10/06 D43725 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD MAHMOD par) | 32. Hegistrar's Signatura ARIG Timodium, 31. Date filed (Month, Day, Year) State FEB 1 5 2006

Registrar

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EBRUARY

State of Maryland / Department of Health and Mental Hygiene 📋 🕦 💍 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Antonia Rios 2006 0850 AM 13 rebruary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Saint Agnes
5. Social Security Number Baltimore

If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Hospita 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2√2 F Yrs. Director 73 084-56-4539 June 13, 1932 Puerto Rico Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits , or items 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2□No Director MD Howard COlumbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9422 Kilimanjaro Road death 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 2□ No Specify: Puerto Rican þ Specify: 3 ☐ Widowed 4 ☑ Divorced natural Hispanic Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than ' Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygier Importent: If Item 27 is marked other th any injury or other traumatic avent, the once. 12 Office Worker Clerical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame Be Osvaldo Rios Laura Herrera 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Arlysse Furlow (Daughter) 9422 Kilamanjaro Rd. Columbia MD 21045 (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 2/15/06 Sykesville, MD 21. Signature of Funeral Service Licensee HAIGHT FUNERAL HOME & CHAPEL (Box 195) Blan L. Hugy Sykesville, MD 21784 (410)-795-1400 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Hemorrhage Intracranial 2 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dee to (or as a consequence of): Examiner Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Heart Failure 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 1 Yes 2 No 1 Yes 2 ₩o 25. Was case referred to medical 26. Place of Death | Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending death. 1 ☐Yes 2 ☐ No investigation after death 2 . Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) Molammed MD P17601 February 13, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Sc 2 Begistrar Signare Attack ton Baltimore, MD 21229 Mohamment Avenue Nareesa 31. Date filed (Menth) Day Year) 6 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician Month 02 25-Zaxo /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner McREAL SAL+ Mar Q Year If Under 24 Hrs. MAYLAND Onke Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year Birthplace (State or Foreign Country) **Funeral** 7-92-469 Months Days Min 1 □ M 2 XF Hours Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10a. State City, Town or Location 10b. County 10d. Inside City Limits or 28a-f show injury or other traumatic event, the Mudical Examiner must be notified at 1 No 2 No Funeral Director Street and Number 10g. Citizen of What Country? 10f. Zip Code or Items 23a Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes W No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 20 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Š Specify ack 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than " Elementary/Secondary (0-12) 1 KNOW 17. Father's Name (First, Middle, Last, Mother's Name (First, Middle, Maiden Sumame Be 19b. Mailing Address (Street and Number or Rural Route Number, or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mathod of Disposition

Burial 2 ☐ Cremation 3 ☐ R

Donation 5 ☐ Other (Specify) athod of Disposition 3 Removal from State 21. Signatur of Funeral Service Licensee à 23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. dying, such as cardiac or respirator Approximate Interval Betwe Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician winner /Medical Due to (or as a consequence of) Examiner in traventice Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. the burial-transit the attending physician and Division of Vital Records, P.O. Box 68760, Physician/Medical detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 4□Pregnant at time of death 5 ☐ Other (specify) Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 Probably Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 1 TYes 1 Yes 2 No 2 2 No the funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' 2 No Hospital: Other: 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manner of Ceath 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one)

within 24 hours after death To the Funeral Director: completely filled in by

7 State Registrar

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Rem 23a) (Type, Print)

22



29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible., perFH, 63532, 2/27/06 TT State of Maryland / Department of Health and Mental Hygiene Amend item#8. perFH. 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Yeer ava 05 2006 -ebruarvII /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 3 aketh Baltimore (1 Wising If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 9 5. Social Security Number 6. Sex 7. Age (In)yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 213-20-1999 Usual Residence of Decedent 1 M 2 M Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at 1 Yes 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 3 No Specify: Completed by 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NQT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "na any niury or other traumatic event, in a Made anse. Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) Be 18 Mother's Name /First Middle Malden Sum 2 mber on Rural Route Number, City or 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Nur 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Other (Specify) Mineral Service Vicenzee 21. Signature of 22. Name and Address of Facility ter had sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest replant allure. List only one cause on each line. Approximate shock or b Interval Between Onset and Death Immediate Couse (Final disease on indition resulting in death) **Physician** emen 1-eavs /Medical Due to (or as a consequence of): Examiner EMV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit CA ear. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 WNo
9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Winknown 1 ☐ Yes 2 ☐ No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performe 2 **X** No 2 🗌 No 1 Yes 1 ☐ Yes or Attending Physicien: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 X)No Hospital: Other: Certification: To 1 🗌 Yes 1 🗌 Inpatient 4 X ursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA Manner of Death
Natural
Accident funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the Director: 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel within 24 hours To the Funeral 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) venue ensin 31. Date filed Month, Day, Year) 32. Registrant Signature State Registrar

			For State Registrar	State of M	laryland / Dep	ertificate of I		and M		iene () (	)6	04343
	Physicia	an	1. Decedent's Name (First, Middle, L	ast	)				<ol><li>Date of Dear Month</li></ol>	h Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, gr	REVICX	-1	45 City Taylor		4 D - 4 h	02	09 2 4c. Count	006	03:35p <sup>M</sup>
?	Examin	er			"	4b. City, Town, or Baltimo		n Death		4C. County	OIDBall	1
K.	Funeral		5906 Bland Ave	Sex 7. A	ige (In yrs. last birthda)	) If Under 1 Year	If Under		8. Date of Birth	Vasal	9. Birth	nplace (State or Foreign untry)
	Director		219-18-2740	1 □ M 2 <b>X</b> ] F	83 Yrs.	Months Days	Hours	Min.	(Month, Day, 08 24		Col	MD
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or I	ocation					1	10d. Inside City Limits
	danyli 1 eho	ō	MD NA		Baltim							1 XYes 2 □ No
	death with the Maryland ime 23s or 28s-f ehow r instal be trofflied at	Director	10e. Street and Number		Darcin	10f. Zip Code			1	0g. Citizen of	What Co	untry?
	h with		5906 Bland Ave	2		21	.215			U.	S.A	•
	J within 72 hours after death with the Marylan riben - riben - neturet, or Iteme 23a or 28a-1 show the Medical Esaminat mark to rediffed at	Funeral	11. Marital Status	12. Was Deceder Armed Forces	nt Ever in U.S. 13	. Was Decedent of H If Yes, specify Cuba	ispanic Original	gin? (Spo	ecify Yes or No- Rican, etc.)		ce - Amer	ncan Indian,
9	s after	by Fu	1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	1 Tes 1 If Yes, Give Year or Dates	]No	1 ☐ Yes 2 ☒ No	Specify:		,	Specia	h.c.	
3	filed within 72 hours after Hygiene. ther then "neturel", or ite sit, the Medical Examina		15. Decedent's	1	16a, Dec	edent's Usual Occup	ation			16b. Kind of B		lack
213-0030	nin 72 na "na	Completed	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4o	(Giv	re kind of work done DO NOT use retired	during mos	t of work				·
7	filed with Hygiene ther the	E O	12th grade	na:	Sch	ool Secr	etar	У		Dept o	of E	ducation
5		Be	17. Father's Name (First, Middle, Las	t)					(First, Middle,	Maiden Sumai	ne)	
Ž	should be nd Mental nmarked c	ဥ	George Wilson						Ricks			
maryland	0 4 - 8		19a. Informant's Name/Relationship			iling Address <i>(Str</i> eet Western						(ip Code) 21215
	s 1 end f Health item 27 other to		Gerald Burton  20a. Method of Disposition	-2011		position (Name of ematory or other place			Date	20c. Location		
100	60		X\sqrt{Surial} 2 \sqrt{Cremation} 3 4 \sqrt{Donation} 5 \sqrt{Other} (Spec	☐Removal from Stat	.9	_	_ 1	2/15	106	Arbuti	-	
saitimore,	当 を 日本		21. Signature of Fungrat Service Lic			Memoria 22. Name and Addre	ss of Facilit	ty	/00	ALDUL	15,	тa
ñ	Pen Dep Pen Pen Pen Pen Pen Pen Pen Pen Pen Pen		Vinette	5K.5	mes M	larch F/H 1300 Waba	H Wes	st Ve.	Balti	more.	Md	21215
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	nplications that caus								Approximate Interval Between
	Pnysician :		Immediate Cause (Final disease or condition	En	Ustage	Rena			easc		ļ	Onset and Death
,	/Medical Examiner		resulting in death)	Due to (or a	as vicons—u rice of);		-					1/2
	Cxammer	<u>.</u>	Sequentially list conditions,	b. Due to (or a	Uperes .							year
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	His	is a consequence of):	Din						VOULCE
,	execunand nand	Exar	that initiated events resulting in death) Last	C. Due to for a	as a consequence of):				-			1000
20	certificate be executed adding physician and use as the burial-transit	cail		d								
g	ntifica ng ph as th		IF FEMALE:									
ŏ	leath certific ettending p	Physician/Med	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1□Live birth		B Ectopic pregnancy	,			1	ate of deli	ivery Day Year
5	0 0 0	/sic	1 Yes 21 No	4□Pregnant 9□ Unknown		Other (specify) _			<u> </u>		Ontri	bay roa
7.	The law requires that the ate has been signed by the page 2 should be detache		Part II. Other significant conditions	contributing to death	but not resultin@n the	underlying cause giv	en in Part I		23e. Did to	bacco use cos	tribute to	the cause of death?
Hecords,	uires thai signed t ld be det	d by	Congertiu	o ho	et tai	Ille.				es 2 DNo		obably 4 Unknown
င္ပ	w require been sig should b	Completed	1						24a. Was a	ın 24b.	Were au	itopsy findings available
E E	hysician: The law his certificate has b I director, page 2 s	E O					-		autop: perfor	med?	prior to death?	completion of cause of
VItal	an: Trifica	a	25. Was case referred to medical				26. Place	of Deat	1 ☐ Yes	2 2 No	1 103	210 110
>	Attending Physician: r death. ector: After this certificaby the funeral director.	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{DNO} \)	Hospital: 1  Inpa	itient 2 ER/Outpati	ent 3 DOA	er: 4 □ Nu	ursing Ho	me 5 Desid	ence 6 🗆 Ot	her (Spec	cify)
o <u>-</u>	ding Ph h. After th funeral		27. Manns of Death 1	28a. Date of Ir (Month, I	nju <i>r</i> y 28b. Time Da <i>y</i> Year) Injury	Wo			28d. Describe h	ow injury occu	rred	
<u> </u>	r Attendi er death. rector: A by the fu	cat	2 Accident investigat 3 Suicide 6 Could not	be -			Yes 2 🗌	No	2001			
DIVISION OF	or At after of Direction by	ertification;	4 Homicide determine	d 288. Place of	Injury - At home, farm, etc. (Specify)	street, factory, office			City or Tow		ber or Hu	ural Route Number,
_	To the Hospitel or Attentwithin 24 hours after deatl To the Funeral Director: completely filled in by the	O	29a. Certifier 1 Certifying	Physician: To the be	st of my knowledge, de	ath occurred at the til	me, date an	nd place	and due to the	ause(s) and m	anner as	stated.
	Hos	Medicai	(Check only 2 Medical Ex	aminer: On the basis and manner	of examination and/or	investigation, in my	pinion, dea	th occur	red at the time,	late and place	, and due	to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	2 10.	n/h	29c. Licens	se number			9d. Date sign	ed (Mont	h, Day, Year)
	0		> WILL	h Xlee	1 ho	Da	248	88	19	elou	en	13,2006
1	1		30. Name and address of person wh	o compreted cause o	f death (Item 23a) (Typ	e, Print)/	26		1	Q.	H.	Deales.
Š	)		NIEN INFINE	XXXOM 1	VIN 222	, W. WO	SPY	124	care	1001	111	AU NOSPI
7	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 5	2006 32. Regi	strar's Signature	Sugar His				,		
	, region		LED T 9	TOOO   VEN	was so	THE PERSON OF TH						

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			For State Registrar	State of Maryla		artment of rtificate of			gieņe Reg. No.	06	04344
44	Physici	an	Decedent's Name (First, Middle, Last)     Edward G. Ruf	·				2. Date of De Month	ary 10,	2006	3. Time of Death 10:45 P M
	/Medic Examir		4a. Facility Name (If not institution, give so Charlotte Hall Ve				or Location of C	eath	4c. Cou	inty of Death	·
	Funeral Director		370 37 2029 11	7. Age (In yi M 2□F 76	rs. last birthday) Yrs.	If Under 1 Year Months Days	r If Under 24 Hours	Hrs. 8. Date of Bir Min. Month Da	rth Y-9239	9. Birthp	place (State or Foreign htry)
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince Ge	_	City, Town or Lo	ucation Upper Ma	rlboro			1	10d. Inside City Limits 1 ☐ Yes 2 \ No
	h with the 23a or 28	Funeral Director	10e. Street and Number 9527 Nottingham	Drive		10f. Zip Code 2077	'2		10g. Citizen	of What Cour S.A.	ntry?
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or items 23e or 28a-f ahow important; If Item 27 is marked other than "netural", or items 23e or 28a-f ahow propriaty or other traumatic event, its Madicial Expinition must be collined at ODGs.	þ	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	If Yes, Give	951-1	Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 ☐ No		? (Specify Yes or No uerto Rican, etc.)		Race - Americ Black, White, ecify: W	
21215-0036	d within 72 hogiene. giene. er then "netu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done DO NOT use retir d Librai	ed) during most of	working		f Business/In	·
Maryland	2 should be filed within and Mental Hygiene. Fis marked other than "reumatic event, the Mad	To Be (	17. Father's Name <i>(First, Middle, Last)</i> Harold Edward Ru:	£				Name (First, Middle Na Louise		name)	
	and 2 sho saith and n 27 is m		19a. Informant's Name/Relationship (Type Barbara A. Ruf (Wi	fe)	9527	Notting	gham Dri	or Rural Route Numb ve Upper	Marlbo	ro, MD	20772
Baltimore,	Pages 1 nent of He ant: If Iten ury or oth		20a. Method of Disposition  1 ★ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	- State	esurrect	natory or other pl ion Ceme	etery 2	ebrüäry 15 2006	Clint	on, Ma	ryland
Balt	permit. Departr Imports any inji		21. Signature of Funeral-Service License	M0015				Lee Funer Iria Ferry			n, MD20735
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	ations that caused the decause on each line.  UVOSC  Due to (or as a cons	eath. Do not en	er the mode of dy			arrest,		Approximate Interval Between Onset and Death
8760,		dical Examiner	S. Juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	seque e of):	vieny scul z Al	dise ar zher	Pase Acci mev!	dent s.	-	
O. Box 6	ath certific ttending p or use as	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	ic. If yes, outcome of predictions of the second of the se	etal death 3	⊒Ectopic pregnan ⊒ Other (specify)	су		23d.	Date of delive Month	ery Day Year
α.	vires that the de signed by the a Id be detached f	d by PI	Part II. Other significant conditions contact Renich Pros	nbuting to death but not	resulting in the u	nderlying cause g	iven in Part I.		tobacco use		he cause of death?
Records,	e law has b	Completed	Osteoarth	itis		- 1 - 3 - 9		24a. Was	opsy ormed?	prior to co death?	opsy findings available ompletion of cause of
Vital	Physician: The this certificate ral director, pag	To Be C	25. Was case referred to medical examiner? Value 1 Yes 2 No He	ospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3 DOA	26. Place of	Death Check only		1 Yes	
Division of Vital	fter ne	Certification; T	27. Manner of Death  1	28a. Date of Injury (Month, Day Year) 28e. Place of Injury - A	28b. Time of Injury	f 28c. Inj W M 1[	uryat ork? ⊒Yes 2⊡No	28d. Describe	how injury of	ccurred	al Route Number,
Ö	To the Hospital or Attencembin 24 hours after death To the Funeral Director: completely filled in by the	ai Cert	29a. Certifier 1 - Certifying Phys	building, etc. (Special of my lician. To the bast of my lician.	enowledge, deat	h occurred at the	timo, Jata sno-	Jane and due to the	own, State)	f mannor as s	teloh
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A cumpletely filled in by the fu	Medical	(Check only 2 Medical Examinone)  29b. Signature and title of certifier	er: On the basis of exam and manner stated.	anation and/or in		opinion, death	occurred at the time		gned (Month,	
	121		110 Hospital	repleted cause of death (I	20	Print) F	rul Jan	i_M.D.	cle,	MD	20678
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si	gnature				,		

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Registrar

ATHERIN

Side of

	4 100	epartment of Health and Menta Certificate of Death	al Hygiene 006 04346
Physi <b>ð</b> :an	1. Decedent's Name (First, Middle, Last)  Deborah Ann Reese	M	ate of Death onth Day Year 3. Time of Death onth 4:30 PM
/Medical Examiner	4a. Facility Name (If not institution, give street and number)  Frank() Squark Hospit.  5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	4b. City, Town, or Location of Death  ROSE dale	4c. County of Death BALTIMORE
Funeral Director	218-72-8257  Usual Residence of Decedent	Months Days Hours Min. (M	te of Birth onth, Day, Year)  1955 Maryland  9. Birthplace (State or Foreign Country)  Maryland
the Maryland 28a-fehow notified at	10a. State 10b. County 10c. City, Town of		10d. tnside City Limits 1 ☐ Yes 2 ☑ No
with the Mar a or 28a-f or the notified	10e. Street and Number  44 Sandstone Court	altimore 10f. Zip Code	10g. Citizen of What Country?
deeth v ma 23 r must		21236  13. Was Decedent of Hispanic Origin? (Specify Y If Yes, specify Cuban, Mexican, Puerto Rican,	es or No- elc.)  14. Race - American Indian, Black, White, etc.
0036 ours after Felt, or its Exercise 1 by Fu	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 🕅 No Specify:	Specify: White
altimore, Maryland 21215-0036 mit. Pages 1 and 2 should be filed within 72 hours after partnament of Healing and Maniel Hygiene. promoting the marked other then "neturel", or its y injury or other traumatic event, the Madical Example 4 injury or other traumatic event.	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of working e. DO NOT use retired)	16b. Kind of Business/Industry
Ind 212 be filed with the Hygiene. d other there event, the		ver Worked  18. Mother's Name (First	Never Worked , Middle, Maiden Surname)
Tarylar 2 should be and Mente in marked aumatic ev	vernon k. keese	Catherine lailing Address (Street and Number or Rural Rout	
PESSE JANOTE MORY IN MORE STANDING TO HEAlth and More of Health and More of the other traumatic y or other traumatic	Katherine E. Prochazka (sister) 4	4 Sandstone Court, Bal	timore, MD 21236
Pages in ment of hant	1 Burial 2 Cremation 3 Removal from State	crematory or other place)	20c. Location - City or Town, State  6 Baltimore, Maryland
Baltimol Bantimol Permit. Pages Department of Important: If is eny injury or ones.	21. Signature of the ral San Gensee	22. Name and Address of Facility Schimu 9705 Belair Rd., Balt	nek Funeral Homes
68760.  Ilicate be executed.  Applysicien and as the burial-transit edical Examiner.	d	nany ARREST CER	Iratory arrest, Approximate Interval Between Onset and Death
Box eath cert ettendin for use	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Ves 2 No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)	23d. Date of delivery  Month Day Year
Cords, P wrequires that been signed to should be det		e underlying cause given in Part I. 23	3e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Nrknown
Division of Vital Records, P.O. effect death.  I or Attending Physicien: The law requires that the definer death.  Director: After this certificate has been signed by the sin by the funeral director. page 2 should be detached ertification; To Be Completed by Physicial and the statement of the s			4a. Was an autopsy available prior to completion of cause of death?  Yes 2 \sum No 124b. Were autopsy findings available prior to completion of cause of death?
of Vital Physicien: rthis certifice ral director. g	examiner?  1 X Yes 2 No Hospital: 1 Inpatient 2 X FR/Outpa		ck only one)  ☐ Residence 6 ☐ Other (Specify)
Vision of Attending Phr r death. ector: After thin by the funeral	27. Manner of Death  Naturat 5 Pending  Accident investigation  28a. Date of Injury  (Month, Day Year)  Inju		escribe how injury occurred
Division C To the Hospital or Attending P within 24 hours elter death. To the Funeral Director: Alter t completely filled in by the tuneral Medical Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		cation (Street and Number or Rural Route Number, ty or Town, State)
thin 24 hours to the Hospital thin 24 hours to the Funeral implately filled	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, d 2 Medical Examiner: On the basis of examination and/o	eath occurred at the time, date and place, and du r investigation, in my opinion, death occurred at ti	e to the cause(s) and manner as stated. he time, date and place, and due to the cause(s)
To the trought of the		29c. License number	29d. Date signed (Month, Day, Year)
A	30. Name and address of person who completed cause of death (Item 23a) (Ty	D 5 4 4 Z 8	2/11/2006 AUTIMORE, MO 21237
State Registrar	31. Date filed (Month Day, Year) 22. Registrar's Signature	ill	+411110100 1110 2120 /

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State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year ENRIQUE 8:50 PM REGON DOLA FEBRUARY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOHNS HOSSITAL BALTIMORE THE HOPKINS 414 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) 9. Birthplace (State or Country)

Wonths Days Hours Min. July 15, 1921 Philippines 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F 84 Director 218-15-4265 Yrs Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits the Medical Examiner must be notified at Director Maryland Baltimore 1 ☐ Yes 2 No Nottinaham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 9129 Kilbride Road Items 23a 21236 U.S.A. deeth Funeral 12. Was Decedent Ever in U.S. Amed Forces? 1 Xi Yes 2 □ No If Yes, Give Year or Dates: WW 77 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Peges 1 and 2 should be filled within 72 hours after 1 Never Married 2 Married ö Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Filipino Š 3 ☐ Widowed 4 ☐ Divorced "naturel', Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Self-Employed College (1-4or 5+) 7th Grade Farmer Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental le marked Regondola Maximo Gregoria Rubis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Edna Ramos item 27 l (daughter) 9129 Kilbride Road, Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Importent: If its eny Injury or ot pnce. 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Bayview Crematory 2/20/2006 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Homes Buin a. Willem 9705 Belair Road, Baltimore, MD 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician AULEST BRADYCARDIL 24 Hours /Medical Due to (or as a consequence of): Examiner INTRAABDOMINAL 3 WEEKS Sequentially list conditions.

Lany, leading 1, immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner The law requires that the death certificate be executed physicien and s the burial-transit fore NECKOTIC WARLE resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day 4□Pregnant at time of death 5 Other (specify) signed by the e 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Completed by been si 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an cate has page 2 s autopsy performe 2 No 1 ☐ Yes 2 No 1 Yes or Attending Physicien: director Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes Hospital: Certification: To 2 K No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred s after dec. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated å 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES- A54147357 MD FEBRUARY 11, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL T. FREEHUL BALTIMORE, MD. 21287-9106 600 NORTH WOLFE STREET 31. Date filed (Month, Day, Year) 32. Restrar's Signature

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State

Registrar

FEB 1 5 2008

			For State Registrar	State of Ma	-	partment of ertificate of		nd Mental Hyg	giene 006	04348		
	Dhusisi		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day Year	3. Time of Death		
	Physicia /Medic		TYLER	Р.	RUI	DD I E		FEBRUAR				
	Examin	er	4a. Facility Name (If not institution, give s NORTHWEST HOSPITA	L CENTER	4		LSTOWN		4c. County of Dee	RE		
	Funeral Director			7. Ag	e (In yrs. last birthd 56 Yrs	Months Days		Min. APR. 28	1949	thplace (State or Foreign ountry)  MD		
	ow ow		Usuel Residence of Decedent  10a. State 10b. County	2	10c. City, Town o	Location				10d. Inside City Limits		
	Many B-f sh	tor	MD BALTIMO	RE	RE	ISTERSTOWN	1			1 ☐ Yes 2 🔀 No		
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	•		
	s 23a	ral	510 BOND AVENUE	10 Was Dagedant	Fires in 11 C	IS Was Deceded of	211		14. Race - Am	USA erican Indian		
980	J within 72 hours after death with the Maryland jiene. Than "natural", or items 23a or 28a-f show the Medical Evantral must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	If Yes, specify Cu		in? (Specify Yes or No- Puerto Rican, etc.)	Black, Whi			
5	72 ho	eted	15. Decedent's Edu (Specify only highest grade			ecedent's Usual Occu		of working	16b. Kind of Business	s/industry		
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	e. <i>DO NOT</i> use retir DIATRIST	ed)		MEDICAL			
d 2	Hyg Hyg int,		17. Father's Name (First, Middle, Last)	Т	PU	DIAIKISI	18. Mother	's Name (First, Middle,				
Maryland 21215-0036	e d ai	To Be	ISRAEL		RUDD		1	VIA		BLUMSTEIN		
Mar	12 s		19a. Informant's Name/Relationship (Ty) LYNN RUDDIE / WIF	-				or Rural Route Number REISTERSTO				
<u>ق</u>	1 an Heal em 2 ther		20a. Method of Disposition		We 5,544.00	sposition (Name of crematory or other pl			20c. Location - City o			
<u>0</u>	0 0		1  Burial 2  Cremation 3  R  1  Donation 5  Other (Specify)	lemoval from State				2/14/06	BALTIM	ORE, MD		
Baltimore,	permit. Pag Depertment Important: I any injury o once.		21. Signature of Funeral Service License	Cettle	4	22. Name and Add	ress of Facility	SOL LEVINS	SON & BROS	., INC.		
			23a. Part1. Enter the disease, or compli shock, or heart failure. List only or	ications that cause ne cause on each li	d the death. Do not	enter the mode of dy	ring, such as o	ardiac or respiratory ar	rest,	Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition resulting in death)	a	Myocarl	ial In	farct	idn		Onset and Death		
10	/Medical Examiner		resulting in death)	Due to (or as	a consequence of)							
ji.	# 2	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):									
	cuted nd ransit	Examine	cause. Enter Underlying Cause Unsuse or mind y that initiated events  C.									
60,	cate be executed physicien and the burial-transit		resulting in death) Last	Due to (or as	a consequence of)							
68760,	physics the t	dica		d								
Вох	The law requires that the death certificate be executed the face of the attending physicien and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetel death	3 □Ectopic pregnan 5 □ Other (specify)	су		23d. Date of di Month	elivery Day Year		
ds, P.O.	ires that the signed by	by	Part II. Other significant conditions con	•	-	, ,		23e. Did to	obacco use contribute	to the cause of death?		
of Vital Records,	w require	Completed	Hypertons Hypertons					24a. Was	an 24b. Were a	autopsy findings available		
Re	tician: The lav certificate has rector, page 2	dmo	- 17 9 por Tipino	m/q		····		autop perfo		completion of cause of		
ital	(Q ==	BeC	25. Was case referred to medical				26. Place	of Death (Check only o		3 200110		
) \	Physician: r this certificanal director, i	To	IL res 2M No	lospital: 1 ☐ Inpati	-	THEFT 3 DOX	_	sing Home 5 🗆 Resid		ecify)		
on c	Jing P	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Tim ay Yeer) Inju	ry W	uryat ork? ⊒Yes 2 □ N		now injury occurred			
Division	Attence death	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of In	jury - At home, farm	, street, factory, office		28f. Location (S	Street and Number or I	Rural Route Number,		
Š	el or safter safter safter saft Dire	Certi	4 Homicide	building, e	tc. (Specify)			City or Tov	vn, State)			
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exemi	sicien: To the best iner: On the basis of and manner s	of examination and/	leath occurred at the or investigation, in my	time, date and opinion, deat	d place, and due to the h occurred at the time,	cause(s) and manner a date and place, and di	as stated. ue to the cause(s)		
	To th within To th comp	Me	29b. Signature and title of certifier			29c. Lice	nse number		29d. Date signed (Mor	nth, Day, Year)		
			Man m	7,7,		D	4256	/	2/13/0	6		
			30. Name and address of person who co	ompleted cause of	death (Item 23a) (T	/pe, Print)				~		
	- 01		Martin Passe. 31. Date filed (Month, Day, Year)	1, M. D. 2	rar's Signature	als Dr. #4	00 Oh	rings mills,	190 2111	/		
	Regist	ate rar	FEB 1 5 20	306	المكامر مري	halls						

			1 - For State Registrar <b>Amend Item</b>	State of Marylar					ınd M		giene () ()	6	043	49	
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Satterfi	eld					2. Date of Dea Month	Day	Year Zec6		Death _4 M	
	Examin	er	4a. Facility Name (If not institution, give s			4b. Cit	y, Town, or				4c. County		1		
	Funeval		Good Samaritan  5. Social Security Number 6. Sex		last birthday)	If Und	Balt er 1 Year	imore		8. Date of Birtl	NA  Birth 9. Birthplace (State or Foreign				
h	Funeral Director			M 2□F	Yrs		s Days	Hours	Min.	(Month, Day	7, Year) 45	Col	intry) Md.	r r Greigh	
	<u>و</u>		Usual Residence of Decedent												
	arylar show	_	10a. State 10b. County		ty, Town or Lo							10d. Inside Ci	-		
	the M	ecto	Md. N	A	Balt	_					10 000				
	with	ä	713 Benninghaus R	bso		107. 2	ip Code 212]	2			10g. Citizen of \	vnat Cot SA	untry?		
	death ms 23	Funeral Director		12. Was Decedent Ever in U	I.S. 13. V	Was Dec	edent of His	spanic Orio	ain? (Spe	cify Yes or No-	Υ		rican Indian,		
9	after or ite	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No		If Yes, sp	ecify Cubar	n, Mexican,	, Puerto F	Rican, etc.)		Black, White, etc.			
8	filed within 72 hours after death with the Maryland Hyglene. ther then "neturel", or Items 23e or 28e-f show thit, the Medical Evertiner must be notified at	d by	3 Widowed 4 Divorced	1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates:		1 L Yes	2 X No	Specify:			Specify	" Bla	ack		
2	"nett	Completed	15. Decedent's Educ (Specify only highest grade		(Give	kind of v	sual Occupa vork done d	uring most	of working	ng	16b. Kind of B	ısiness/lı	ndustry		
7	withir ene. then	щ	Elementary/Secondary (0-12)	College (1-4or 5+)			use retired)								
<u>0</u>	Hygi other ent, L	Be C	12th grade 17. Father's Name (First, Middle, Last)		1 Tec	chnic	cian	18. Mother	r's Name	(First, Middle,	Electi Maiden Suman		C		
Maryland 21215-0036	should be filed within 72 hours after death with the Marylan nd Mental Hygjene. marked other then "neturel", or Items 23e or 28e-f show maite event, the Medical Evernment te routilised at	To B	Jesse	Satt	erfiel	Lđ		El	lnora	ì	I	aylo	or		
ary	and has ma	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Addre	ss (Street a	nd Numbe	r or Rura	Route Numbe	r, City or Town,	State, Z	ip Code)		
<b>≤</b>	and and m 27		Georgia Mae Satte				ningha	us F			ore, Md.		21212		
more,	ges 1 t of H if itel		20a. Method of Disposition  15 Burial 2 Cremation 3 Re	emoval from State	Place of Dispo cemetery, crer	matory of	r other place		D	ate	20c. Location -	City or T	Town, State		
≣	t. Pa rtmen rtent: njury		`4 Donation 5 Other (Specify)		Garden				/18/		Baltimo		<b>D.</b>		
Balti	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 is marked any injury or other treumatic es 2002.		21. Signature of Funeral Service License	100 C	100		and Addres		•		timore,		21202		
			23a. Part1. Enter the disease, or complic	cations that caused the deal			F.H.				E. North	1 AVE	Approximate		
d	Enysician		snock, or neart failure. List only on Immediate Cause (Final	e cause on each line.									Interval Bet Onset and I		
1	/Medical		disease or condition resulting in death)	Due to (or as a contect		Cer		va e	tus.	tatic		_	yea.	-5	
Ö	Examiner		Sequentially list conditions b.										(		
X	p ii	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Usease or injury	Due to (or as a consec	(uence of):										
R	and and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	Theuce ot).										
8760,	cate be executed obysician and the burial-transit	dlcal E			(30,100 0.7)										
မ	ificate g physas the	edlo													
Вох	The law requires that the death certifica ate has been signed by the attending pt page 2 should be detached for use as it	Physician/Med	23b. **as decedent pregnant	3c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta		TE et opio	pregnancy				23d. Da	te of deliv			
B	s deat he att	sicie	in the past 12 months? 1 ☐ Yes 2 🙀 No	4 Pregnant at time of o			specify)				Mo	nth	Day h	Year	
s, P.O.	that the de led by the a detached f	Phy	9 Unknown			. 4. 4		1		00- 0:44		-12	Ab 4 -l	11-0	
S,	iw requires that s been signed t should be deta	þ	Part II. Other significant conditions con		suiting in the u	naeriying	cause give	n in Paπ I.			obacco use cont res 2 🗆 No	ribute to 3 ( <b>∑</b> (Pro		Jnknown	
Ö	r requ	etec	diaretes m	- fe: (						24a. Was			70070	-	
Rec	he tav s has ge 2 :	Completed	altaretes wellifus								sy	were aut prior to co death?	topsy findings a completion of ca	available ause of	
ā	Physicien: The ta r this certificate has iral director, page 2	ပိ	25. Was case referred to medical					26 Place	of Death	1 ☐ Yes (Check only o		1 🗌 Yes	2 No		
>	ysicie is cert direct	0 8	examiner?	ospital: 1 Unpatient 2	ER/Outpatier	nt 3□ [	OOA Othe	N#1			ne) lence 6 ∏Oth	er (Spec	eifv)		
פר	Attending Physicien: r death. ector: After this certific. by the funeral director, I	T:u	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury Work	V V			now injury occur		,,		
<u>0</u>	endir eath. or: Af	catle	2 Accident investigation	(,,		М		/es 2□N	No						
Division of Vital Record	or Ati	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, str fy)	reet, facto	ory, office		2	8f. Location (S City or Tow	Street and Numb m, State)	er or Rui	rai Route Num	ber,	
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral		29a. Certifier † Certifying Phys	rician. To the heat of much	Ouded to 1	<u> </u>		- d	9	mal also = 4 = 44	201101-1-1				
	9 Hos 24 hr 9 Fun etely	edical	(Check only one)	icien: To the best of my known and manner stated.	ation and/or in	vestigation	on, in my op	e, cate and inion, deat	u piace, a th occurre	nd at the time,	ause(s) and ma date and place,	and due	to the cause(s	)	
	To thi within Fo the	Me	29b. Signature and title of certifier			2	9c. License	number			29d. Date signe	d (Month	, Day, Year)	-	
)			1/1/	~			70	0057	5 + 3		Febr	"uc-	111,20	060	
	,0		30. Name and address of person who col	mpleted cause of death (Iter	m 23a) (Type,	Print)	7		0.				-		
	`		David Naman,	5601	och lo	lven	3100	(. 50	cetio	nost I N	2175	٠, ٧			
	Sta Registi		31. Date filed (Month, Day, Year) FEB 1 5 2006	mpleted cause of death (Iter	ature	AL P									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death **Physician** Day /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Date of Birth Month, Day, 9. Birthplace (State or Foreign **Funeral** Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County or 28a-f show 10d. Inside City Limits traumatic event, the Medical Executes must be notified at Director 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23g Completed by Funeral Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Blac 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
Tip. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname 19a. Info 19b. Mailing Address (Street and Number or Rural Route Number, City or ant's Name/Relationship (Type, Pript) Department of Health a Important: If item 27 is any injury or other trains one. 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \* 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 21229 to Natrolal 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ng, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Hospitat or Attending Physician: The law requires that the death certificate be execused anding physician and use as the burial-transit Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ĺ in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 ☐ Other (specify) P.O. | 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 9☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ð Be Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 2 ☐ No 1 Tes 25. Was case referred to medical examiner? 26. Place of Death Check only one) 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's Signature

5 2006

tem 23a) (Typa, Print) , 22 Sauth

			For State Registrar	State of Maryla		artment of rtificate of		and Mental	Hygien Reg. N	000	04351
	Physici /Medic	an cal	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give s		0.11	4b. City, Town,	or Location o	I-e	Druar	ay Year 132 Ic. County of Dear	3. Time of Death COG 226PM
	Funeral Director		EL TITOGOL A	1/	entev s. last birthday) Yrs.	If Under 1 Yea Months Days			th, Day, Yea	946 Mar	thplace (State or Foreign country) yland
	Ba-f ahow	Director	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimor		Reiste	rstown					10d. Inside City Limits 1 ☐ Yes 2 ☑ No
36	72 hours after death with the Maryland naturel; or items 23a or 28a-f ahow disel Examinat must be notified at	by Funeral Dire	1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		10f. Zip Code 211 Was Decedent of f Yes, specify Cu	Hispanic Original ban, Mexican	gin? (Specify Yes i, Puerto Rican, et		U.S.A.  14. Race - Ame Black, Whit	erican Indian,
Maryland 21215-0036	f within liene. r than "	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)  1.2  1.5. Decedent's Edu (Specify only highest grade (0-12)  1.5. Elementary/Secondary (0-12)  1.5. Father's Name (First, Middle, Last)		(Give	dent's Usual Occi kind of work don DO NOT use retir tance Ma	e during mosi ed) n			Kind of Business,	
laryland	should be and Menta a marked aumatic av	To Be	Steven John 19a. Informant's Name/Relationship (Ty	oe, Print)			H at and Numbe		y Myen	or Town, State, 2	Zip Code)
Baltimore, M	of Heal of Heal fitam 2		Mary Louise Saf:  20a. Method of Disposition  1 Burial 2 A Cremation 3 B  4 Donation , 5 Other (Specify)	20b.	Place of Dispo cemetery, crer	Fitz Ct. sition (Name of matory or other pi rematory	ace)	istersto Date  b. 15. 2	20c.	d. 21136 Location City or altimore.	
Balti	permit. Pag Department Important: i any injury o		21. Signature of vurieral Service Licease  23a. Part I. Enter the disease, or compare service of ball tallurase, or compare tallurase.	99/	22	2. Name and Add	ress of Facilit	γ		2	יי וו
8760, 0	Provided by the provided by th	ical Examiner	shock, or hear failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	VOS equence of); equence of); CUXX	<u>levoti</u> unsion		irdiov		llarc	lufervar permeen
.O. Box 6	The law requires thet the death certificate be executed the has been signed by the attending physicien and oate 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic pregnan Other (specify)	су			23d. Date of del Month	livery Day Year
of Vital Records, P	aw requires thet s been signed b 2 should be deta	Completed by PI	Part II. Other significant conditions cor	tributing to death but not re	esulting in the u	NOND	iven in Part I.		1 ☐ Yes . Was an	2 No 3 Pr	o the cause of death? robably 4 @Unknown utopsy findings available
/ital Re	Physicien: The lav this certificate has ral director, page 2	Be	25. Was case referred to medical examiner?				26. Place		autopsy performed? Yes 2 1	death?	completion of pause of
Division of \	ng Phys fter this ineral dis	Certification: To	27. Manne Death 1	ospital: 1 Inpatient 2  28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Inj W 1	ury at ork? Yes 2	28d. Des		6 □Other (Spe jury occurred	ecify)
Divi	To the Hospitel or Attendi within 24 hours after death. To the Funarel Director: A completely filled in by the fu		4 Homicide determined	28e. Place of Injury - At building, etc. (Spec sician: To the best of my k	cify)			City	or Town, Sta	afe)	ural Route Number,
	To the Hospitei within 24 hours of To the Funarei I completely filled	Medical	(Check only 2 Medical Examinate)  29b. Signature and title of certifier	ner: On the basis of examinand manner stated.	nation and/or in	vestigation, in my	opinion, dea	th occurred at the	time, date a	(s) and manner as and place, and due Date signed (Mont	o to the cause(s)
	1		30. Name and address of person who co	Inpleted cause of death (It	em 23a) (Type,		2005		Fe	bryar	9 14 2006
	Sta Regist		31. Date filed (Month, Day, Year) FFR 1 5 2	32. Abgistrar's Sig	nature	5401	010	l Cour	+ KC	<u>mar</u>	inclassow

			For State Registrar		artment of Health and I tificate of Death	Mental Hygie Reg.	Z 11 11 15	04352
	Physici	an	Decedent's Name (First, Middle, Last)  Debout  James Coults			2. Date of Death Month February	Day Year 12 2006	3. Time of Death 6:02 p M
	/Medi Examir		Robert James Sark( 4a. Facility Name (If not institution, give street an		4b. City, Town, or Location of Death		4c. County of Death	0.02 p
	LXUIIII		Gilchrist Center		Towson		Baltimore	
	Funeral Director		5. Social Security Number 6. Sex 1 1 1 1 M 2	F 98 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Ye March 28,	9. Birthp Coun 1907 Mass	lace (State or Foreign try) achusetts
	lend wo		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation		1	0d. Inside City Limits
	death with the Maryland ms 23a or 28e-f show rmast be notified at	tor	Maryland Baltimore	Towson				1 ☐ Yes 2√ No
	or 28.	Director	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Coun	try?
	s 23a		20 Dunvale Road Apt		21204	US		an Indian
336	within 72 hours after desene. ene. then "naturel", or items he Medical Examiner n	by Funeral	1 Never Married 2 Married 1 1	d Forces? I	Was Decedent of Hispanic Origin? (Sif Yes, specify Cuban, Mexican, Puerlin I ☐ Yes 2 ☐ No Specify:	ecry Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
5-0	72 hou	ted	15. Decedent's Education (Specify only highest grade comple	16a. Deced	lent's Usual Occupation kind of work done during most of wor		. Kind of Business/Ind	
121	Mithin ne.	Completed	Elementary/Secondary (0-12) Colle	ge (1-4or 5+)	DO NOT use retired)	an g	C 0 O Dai	Lugar
d 2	be filed withintal Hygiene.	ပိ	17. Father's Name (First, Middle, Last)	4 ACC	ountant 18. Mother's Nam	ne (First, Middle, Maid	C & O Rai den Surname)	Iway
Maryland 21215-0036	and Mental Hygiene ie marked other thei emarked other thei eumatic event, their	To Be	Frank Sarkozy		Elizab	eth	Unknown	
Man	es 1 and 2 should b of Health and Ment litern 27 ie marked r other treumatic e	N I	19a. Informant's Name/Relationship (Type, Print		ng Address (Street and Number or Ru			Code)
	1 end Health		Diane S. Aschenbrenner  20a. Method of Disposition	20b. Place of Dispo	sition (Name of	rkton, Md.	Location - City or To	wn, State
Baltimore,			1  Burial 2  Cremation 3  Removal 4  Donation 5  Other (Specify).	rom State	natory or other place) ss Cemetery 2/18		leveland,	
alti	permit. Pag Department Important: i any injury o		21. Signature of Funcial Service Livense		. Name and Address of Facility			ork Road
8	8828		lax 1./9/		uck Towson Funera		c. Towson	,Md.21204
	Physician /Medical Examiner	ner	Sequentially list conditions b		Cardiomyopat			Interval Between Onset and Death
8760,	cate be executed physicien and tha burial-transit	dical Examin	Cause (Disease or injury that initiated events c.	e to (or as a consequence of):				
P.O. Box 6	The law requires that the death certific te has been signed by the attending rage 2 should be datached for use as	by Physician/Med	in the past 12 months?		Ectopic pregnancy   Other (specify)		23d. Date of delive Month	ory Day Year
	quires thet in signed t uld be dat	ed by P	Part II. Other significant conditions contributing	to death but not resulting in the ur	ndertying cause given in Part I.	23e. Did tobacc	co use contribute to the	. /
Vital Records,		Completed				24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
Vita	Physician: The rules certificate ral director, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		Other	th (Check only one)	-Ma.	Acces
Division of	B 6	tion: To	1 163 21410	1 🗌 Inpatient 2 🗀 ER/Outpatien  Date of Injury  Month, Day Year)  28b. Time of Injury Injury	4 Industry	ome 5 ☐ Residence 28d. Describe how in		n Nespi e
Divisi	To the Hospitel or Attendit within 24 hours after death. To the Funerel Director: A completely filled in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. I	Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura tate)	l Route Number,
	he Hospil in 24 hour he Funeri pietely fills	Medical (	(Check only 2 Medical Examiner: On t	o the best of my knowledge, death he basis of examination and/or in- manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occu	and due to the cause rred at the time, date	e(s) and manner as si and place, and due to	ated. the cause(s)
	To t com	Σ	29b. Signature and title of certifier		29c. License number		Date signed (Month,	
	1		· Muan	Com	D 58 30 3	fre	bruary 13	2006
10	HIT		30. Name and address of person who completed	cause of death (Item 23a) (Type,	Print) arles St Amest	nor mo	21204	
'E	Sta	_	31. Date filed (Month - Day, Year) 2006	Registrar's Signature	arles St Boust			
	Regist	ar						

Glospm

February 12,2006

SARKOZY RobeRt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend Item #31 Per DVR C852 Certifigate of Death Reg. Nő. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** February Virginia Elizabeth Schultz 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dursing Hartord Grace itizens Home Havre Year Days 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Hours 1 □ M 2 💢 F Yrs. 94 Director 214-26-6134 10/15/1911 Maryland Usual Residence of Decedent the Maryland Show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ltem 27 is marked other than "netural", or items 23e or 28a-f show other traumatic event. The Medical Examiner must be notified at 1 Yes 2 □ No Director Forest Hill Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 108 Jarrettsville Road 21050 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 Is marked other than "netural", or Ite 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11th Assembly Line Worker Spice Company 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be William Ross Laura Cloake ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy Scholl- Step-niece 602 Marjorie Lane, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages Department of Important: If it ţ 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) ö Highview Mem. Grdns. 02/04/06 Fallston. Maruland injury 21. Signature of Funeral Service Licenses Mitchell-Smith Funeral Home, P.A. any it 123 S. Washington, Havre de Grace, MD 21078 Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to ( as a **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician MOSIS Physician/Medical use as IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 24 No Records, P.O. 9 Unknown à been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? chultz, Virginià þ 1 Yes 2 4 No 3 Probably 4 Unknown Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has I ormed? 2 🖸 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 46 Tursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ē this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Abatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 2 Accident filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospitel or The prifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medica (Check or onel 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 2

State Registrar Date filed (Month, Day,

Year

FEB 1

5 2006

DHMH 17 Rev 1/2001

who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

MI

0062903

Union Medical Clinic, 319 S. Union Ave., Havre de Grace

02/03/06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 10, 2006 **Physician** Frances Smith 3:00 ам /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northampton Manor Nursing Center Frederick Frederick If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Jun 01, 1908 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🗓 F 220-10-5209 Maryland 97 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-1 show ?? Is marked other than "natural", or itema 23a or 28a-f sho traumatic event, the Modical Exam har must be notified at Frederick Maryland Frederick 1 XYes 2 No Director 200 East 16th Street 10f. Zip Code 10g. Citizen of What Country? 21701 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23a any Injury or other traumatic event, the Medical Examination 2002. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖔 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates: 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Teacher/Educator Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Hedges Grayson Stalev Bertha Frances Coblentz ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Mercer Ct, #15-8, Frederick, Maryland 21701 Dr. George I. Smith, Jr., Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory | Feb 10,2006 Smithsburg, Maryland 21. Sign tury of Fugeral Service Lice 1340 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 106 Fast Church St, Frederick, Maryland 21701 up Koberson Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Arteriosclerotic Cardiovascular Disease 3 years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner soquentially fut conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-transit or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760, attending physician by Physician/Medical ed by the attending phys detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. g Renal Failure 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? has page 2 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Injury 1 Natural 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital Medical 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely ZU Medical examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (CHECK ONLY one) the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

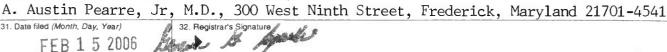
within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

5 2006

31. Date filed (Month, Day, Year)



earre

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D09689

February 10, 2006

		-	For State Registrar	State of	Marylan			t of He		nd Mei		giene leg. No. 0	06	04355
	Physici	**	1. Decedent's Name (First, Midd	Smith						2.	Date of Dea Month	Day	Year 2004	3. Time of Death
	/Medic Examin		4a. Facility Name (Not institution  UniVELSI LU		tospi	tal	4b. City,	Town, or L	ocation of I	Death	Feb	4c. Co	unty of Death	2000
E C	Funeral Director		5. Social Security Number 215-96-6896		1 - 1	last birthday) Yrs.	If Under Months	1 Year	If Under 24	Hrs. 8. Min.	Date of Birth (Month, Day 01/14	, Year) ./1981	Cou	place (State or Foreign ntry)
	pu *		Usual Residence of Decedent  10a. State 10b. County	J	10c Cit	y, Town or Lo	cation							10d. Inside City Limits
	ehoved ed at	5												1 Yes 2 No
	28a-f	Director	MD 10e. Street and Number		ва.	ltimor	10f. Zip	Code				100 Citizen	n of What Cou	nto/?
	with so a		506 Annabel Av	00110				225					ed Stat	•
	death	Funeral	11. Marital Status	12. Was Deced			Was Dece	dent of Hisp	anic Origin	n? (Specif	y Yes or No-		Race - Ameri	can Indian,
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Itams 23a or 28a-f ehow the Madical Exeminer must be natified at	þ	1 Never Married 2 Mai 3 Widowed 4 Divorce	H Voc Civo	No		lf Yes, sped 1 ☐ Yes	cify Cuban, 2 No	Mexican, i Specify:	Puerto Ric	an, etc.)	Sp	Black, White, necify: Am.	etc. Indian
0	2 ho	Completed		nt's Education est grade completed)		16a. Dece		al Occupation		of working		16b. Kind	of Business/In	dustry
21	thin 7	nple	Elementary/Secondary (0-12)	College (1-4	or 5+)	life.	DO NOT us	se retired)	my most o	ii working		Own I	Home	
N	be filed within 72 hc ital Hygiene. d other then "natui event, it e Modical	Con	12			Home	naker							
land		To Be	<ol> <li>Father's Name (First, Middle Renford Smith</li> </ol>					1			First, Middle, .e Simm		mame)	
Maryland	s 1 and 2 should I t Health and Meni Itam 27 ie marke other traumatic		19a. Informant's Name/Relation			1							own, State, Zij	Code)
	1 and Health am 27 ther t		Renford Smith,  20a. Method of Disposition	Jr.	20h F	Place of Dispo		Accordance in the second	venue	Date	timore		21225	own State
Baltimore,	0 0		1 Burial 2 Cremation		ate	semetery, crei	matory or o	ther place)	1	Fe	eb 15			Maryland
Ħ	permit. Pag Department Important: I eny injury o	1	4 Donation 5 Other ( 21. Signature of Funeral Service	<u> </u>		esapea		remato nd Address		nc. 20	106	Dercs	ville,	Maryrand
Ba	permit. Departrimports eny inju		14	well-	Mocas	$^{\circ}$	Cremat	ion ar	nd Fun		Altern			ryland 21286-
100	Physician /Medical		23a. Part 1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	as a conseq	h. Do not en	ter the mod		such as ca	ardiac or r				Approximate Interval Between Onset and Death
	Examiner	liner	Sequentially list conditions, if any, feathing to immediate cause. Enter Underlying Cause (Disease or injury	b. — Due to (or	as a conseq	uence of).								
8760,	be executed sician and burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (or	r as a conseq	juence of):								
687	ficate   physics the t	edical		d.										
P.O. Box (	It the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown		h 2 ⊡Feta ntattime oto	ıl death 3[	⊒Ectopic pi ⊒ Other (sp					23d	I. Date of deliv Month	ery Day Year
S, P	res that the igned by be detact	by Pt	Part II. Other significant condit	ions contributing to dea	th but not res	sulting in the u	inderlying o	ause given	in Part I.		23e. Did to	obacco use	contribute to t	he cause of death?
ord	w require been si should b	ted									1 🗆 Y	′es 2□N	No 3∏ Pro	bably 4 Liaknown
il Record	The lar	Completed									24a. Was autop perfor 1 🗆 Yes	rmed?	prior to co death?	opsy findings available ompletion of cause of 2 No
/ita	ıystcian: Th iis certificete director, pag	Be	25. Was case referred to medic examiner?	Hospital:						of Death (C	Check only o	ne)		
of Vital	this al di	ို	1 Yes 2 No			ER/Outpatie			4 🔲 Nurs				Other (Speci	(y)
		on	27. Manner of Death 1 ⊠Natural 5 ☐ Pend		Day Year)	28b. Time o Injury	M 2	28c. Injury a Work?	at es 2∐No	ļ.	d. Describe h	iow injury o	ccurred	
isi		cat	3 Suicide 6 Could	tigation	f Injune - At h	ome, farm, st			5 2		Location (9	Street and A	Jumber or Rur	al Route Number,
Division	를 를 를 드	Certification:	4 ☐ Homicide deter	mined 286. Place of building	, etc. (Special	fy)	reet, lactor	y, onice		201	City or Tow	m, State)	umber or rur	ar House Wallicer,
	To the Hospital	Medical	29a. Certifier 1 Certify (Check only one) 2 Medice	ing Physician: To the b I Examiner: On the bas and manne	is of examina	owledge, dear ation and/or in	th occurred evestigation	at the time	, date and nion, death	place, and occurred	d due to the a	cause(s) an date and pla	d manner as s ace, and due t	stated. to the cause(s)
200	To the To the comp	ž	29b. Signature and title of certific	er		Λ.	29	c. License		. ()			igned (Month,	
			1/1	4	1	MD		1-10	985	, ,		2	111/0	G
	7		30. Name and address of person Lee-Ann Wi	n who completed cause	of death (Iter	n 23a) (Type 2 S. G	Print)	Str	reet	- B	al to	neve	, M(	21230
	Sta Regist		31. Date filed (Month, Day, Yea	7) 32. Re	gistrar's Sign	ature	1/2 1							

		1 - For State Registrar	State of M	arylan				ealth a Death		Re	g. No.	006	04	356
Physicia /Medic		1. Decedent's Name (First, Middle, Last Ethel V. Sm	nith							2. Date of Deat Feb 9,		Year		e of Death
Examine	40.5	4a. Facility Name (If not institution, give Southern Maryla	ınd Hospit	al			Cli	Location of nton					e Geor	_
Funeral Director			X 7. Ag	e (In yrs. 85	(ast birthday) Yrs.	Months	r 1 Year Days	If Under 2 Hours	Min.	B. Date of Birth Month, Day, OCT 24	, Year) 192	1 Vi	irthplace (Sta Country) .rg1n1a	ite or Fore
72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow digal Exarta entrium the multified at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince  10e. Street and Number	George's	10c. Cit	y, Town or Lo	Washi	ngto p Code	n		11	On Citize	n of What (		e City Lim
23a or	ai Dir	8501 Gibbon	s Drive			101. 21	p Code	2074	4	'			states	
'natural', or iteme 23a or 28a-f ehow idigal Examilian mual ke mulified at	by Funeral	11. Marital Status  1 Never Married AMarried  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 Yes 2 1 If Yes, Give Year or Dates:			Was Dece f Yes, spe i ☐ Yes		spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No- ican, etc.)		Race - An Black, Whoecify:	nerican Indiar nite, etc. White	٦,
then te Mu	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	ucation de completed) College (1-4or	5+)	16a. Dece (Give life. Home!	kind of wo	ork done d ise retired,	urina most	of workin	g		of Busines		
od oth	To Be C	17. Father's Name (First, Middle, Last) Edgar Shaffer						Bert	ie N	(First, Middle, M lay				
7 is		19a. Informant's Name/Relationship (T) Warren A. Smith (								Route Number Ort Wasl				74
ment of Healt ant: If item 2: lury or other I		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ I  4 □ Donation 5 □ Other (Specify,	Removal from State		Place of Dispo emetery, crer dar Hi		me of other place Cemet		14, <sup>Da</sup>				or Town, State	
Departmen Important: any njury once		21. Signature of Funeral Service Licens		_	22	. Name a	nd Addres	s of Facility		Funeral ad, Cli	Home	,Inc	6633 (	
hysicia the bur	dical Examiner	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as d. Due to (or as	Ponseque a ponseque a	uence of):	Del-	- 1	nfe.	ifn					Between and Death
te has been signed by the attending page 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	death 3	Ectopic p					230	d. Date of d Month	elivery Day	Year
e de d	2	Part II. Other significant conditions co	ntnbuting to death b	ut not resi	ulting in the u	nderlying	cause give	n in Part I.		23e. Did tob			to the cause Probably 4	
ate has	Completed								_	24a. Was an autops perform	y /	prior to death?	autopsy findir completion es 2 \( \subseteq \text{No}	ngs availa of cause of
Scer	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:	ent 2 🗆	ER/Outpatier	t 3 D	OA Othe	F		(Check only only only only only only only only		Other (So	ecify)	-
After	ation: T	27. Manyer of Death 1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injury Work		28	3d. Describe ho			,	
within 24 hours after death  To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, et	ury - At ho c. (Specif	ome, farm, str	eet, factor	y, office		28	Bf. Location (St. City or Town		lumb <b>e</b> r or l	Rural Route I	Vumber,
24 hours a Funeral stely filled	edicai	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the best iner: On the basis o and manner st	f examina	wiedge, death tion and/or in	occurred vestigation	at the tim	e, date and inion, deat	i place, ar h occurre	nd due to the ca	iuse(s) ar ate and pl	d manner a ace, and du	as stated. Je to the cau	se(s)
within To the comple	Me	29b. Signature and title of certifier	1.	7		29	c. License	number 245	35	29		igned (Mor	oth, Dey, Yea	ır)
H		30. Mame and address of person who c						- 1/		inton		1/	20735	
Stat	e	31. Date filed (Month, Pay, Year) FEB 1 5 2006	32. Registr				JULL		, 01.					

		For State Registrar	State of Maryland	/ Department	t of Health and e of Death	Mental Hygie	_	04357
Physicia /Medic		1. Decedent's Name (First, Middle, La	·			2. Date of Death Month	Day Year	3. Time of Death
Examine		4a. Facility Name (If not institution, given VN IVERSITY OF MA	RYCARD MEDICAL CE	ENTERZ.	Town, or Location of Deal	F	4c. County of Death	
Funeral Director		5. Social Security Number 6. S 2 18-36-2365 Usual Residence of Decedent	7. Age (In yrs. last	birthday) If Under Months Yrs.	1 Year If Under 24 Hrs Days Hours Min.			nplace (State or Foreignatry)
se Maryland Ba-f show	Director	10a. State 10b. County	10c. City, T	own or Location Himop	<u> </u>			10d. Inside City Limits 1 Yes 2 □ No
eath with the 18 23e or 2	Funeral Dire	877 Leww	12. Was Decedent Ever in U.S.	10f. Zip	Code  2 0   ent of Hispanic Origin? (S		Citizen of What Con	A.
72 hours after death with the Maryland natural, or items 23s or 28s-f show alcal Evana retributive Indillists at	۾	1 Never Married 2 Married 3 Widowed 4 Divorced	Amed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	If Yes, special	ify Cuban, Mexican, Puer	to Rican, etc.)	Black, White	e, etc.
within ane. then *	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation 1 de completed)  College (1-4or 5+)	6a. Decedent's Usual (Give kind of won life. DO NOT use	k done during most of wo e retired)	rking 16	b. Kind of Business/I	ndustry
be filed hal Hyg od othe event,	To Be C	17. Father's Name (First, Middle, Last Happert	Edwind		18. Mother's Nat Anんっ	me (First, Middle, Ma	Miles	
1 and 2 Health a em 27 le ther trai		19a. Informant's Name/Relationship (  A O ANN DRUM  20a. Method of Disposition	a wright 20b. Place	9161 C	(Street and Number or Ri	B11 B	1 4 4 1	21216
permit. Pages Department of I Important: If It sny injury or o once.	Ť	1 Burial 2 Cremation 3 4 Donation 5 Other (Special 21. Signature of Funeral Services Licental Services	y) State	etery, crematory or off	mentary 21	15/04 X	Carror	1
88 8 8	4	23a. Part1. Enter the disease, or com	Janelle State of the death of	1712	w. No-th	Ans		Approximate
Physician /Medical Examiner  be prize - transit  prize -	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence)  C. Due to (or as a consequence)	ce of):				Onset and Death
fice p pl	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown	23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal dea  4 Pregnant at time of death	ath 3 □Ectopic pre			23d. Date of deliving Month	very Day Year
igne bed	ò	Part II. Other significant conditions of	ontributing to death but not resultin	g in the underlying ca	use given in Part I.		cco use contribute to	
The page	Completed					24a. Was an autopsy performer	prior to co	opsy findings availab ompletion of cause o
ding Physick	0.0	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  Natural 5 Pending 2  Accident investigation	28a. Date of Injury (Month, Day Year) 28t	Outpatient 3 DOA b. Time of Injury	Other	ome 5 Residence 28d. Describe how		ufy)
the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the fune	Certification:	3 Suicide 6 Could not b 4 Homicide determined				28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
Hospi 24 hou Funer Hely fill	edical	one)	ysician: To the best of my knowled inter: On the basis of examination and manner stated.	and/or investigation,	in my opinion, death occu	, and due to the caus irred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
To the within 1 To the comple		29b. Signature and the of certifier	Y MO	AU	4176435 S		Date signed (Month,	
		30. Name and address of person who GRAHAM SNYP:	12 22 5. Gas	FENE ST	BATMO	ZF, MD	21201	
Stat Registra	-	31. Date filed (Month, Day, Year) FEB 1 5 200	22. Registrar's Signature	death o				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** FÉBRUARY SEGEL 13, 2006 ELIZAVETA 5:10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JEWISH CONVALESCENT CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) FEB.11,1913 9. Birthplace (State or Foreign Country)
BELARUS **Funeral** 1□M 2▼F 93 220-35-2891 Director Usual Residence of Decedent 10a State 10b. County 10d. Inside City Limits 10c. City. Town or Location or 28a-f show Pages 1 and 2 should be filed within 72 hours after deeth with the Maryla ment of Health and Mantal Hyglene.
and: If Item of 27 is marked other than "natural", or Itema 23a or 28a-f ehov uny or other traumatic event, the Madical Examine must be notified as 1 ☐ Yes 2 ☑ No Director BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7920 SCOTTS LEVEL ROAD 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed by Specify: 3 X Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 5+ College (1-4or 5+) Elementary/Secondary (0-12) TEACHER EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be DYNIN TSIVA KUZNETSOVA YAKOV 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 OAK HILL COURT - OWINGS MILLS, MD 21117 YAKOV SEGEL / SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or once. BALTIMORE HEBREW CEM. 02/14/2006 4 ☐ Donation 5 ☐ Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner the ettending physicien and hed for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 DOnknown Be Completed 1 Yes 2 No been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) 1 Tes Certification: To 2 DNO 1 🗌 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 7 atural 2 Accident 5 Pendina 1 ☐ Yes 2 ☐ No investigation death the within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide the Hospitel cal 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifie, 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death/(Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) 15 2008 Registrar

			1 - For Stete Registrar		State o	f Maryla	nd / Dep		nt of H	lealth a		lental Hy		2006	04359	
	Physici		1. Decedent's Name (First, Mi EDITH LO	ddle, Lasi DUIS	•	ELLJC	NNAH					2. Date of De	ath ARY <sup>Da</sup>	1 <sup>y</sup> 10 Ž <sup>e</sup> a	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institu			-			Town, or	r Location o	of Death		4c. County of Death BALTIMORE			
	Funeral Director		5. Social Security Number 217090719 Usual Residence of Decedent	6. Se	x □ M 2 <b>ॉ</b> F	7. Age (In yrs	s. last birthday) Yrs.	Months	n 1 Year Days	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da MARCH	Birth Day, Year) 1920 MARYLAND			
	Maryland	tor	10a. State 10b. Cou	rty JTIM	ORE	10c. C	ROSED								10d. Inside City Limits 1 ☐ Yes 2 No	
	h with the	al Direc	10e. Street and Number 1213 HILLI	ALE	AVE			10f. Zi	Code 212	237			10g. Ci	tizen of What (	Country?	
980	should be filed within 72 hours efter death with the Maryland of Mental Hygiene. marked other then "natural", or iteme 23s or 28s-f show imatic event, the Mudical Examinational Damoillad and	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ M 3X Widowed 4 ☐ Divord		12. Was Dece Armed For 1 Tes If Yes, Giv Year or Da	rces? 21 No e		Was Dece If Yes, spe 1  Yes		ispanic Origan, Mexican	gin? (Spo n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - An Black, Wh Specify: W		_
21215-0036	d within 72 ho giene. Ir then "natur Ibe Modicel	ompleted	15. Dece (Specify only hig Elementary/Secondary (0-12	hest grac		-4or 5+)	16a. Dece (Give life.	edent's Usu a kind of we DO NOT L HOM	al Occup ork done d se retired EMA I	ation during most () KER	t of work	ing	16b. k	Cind of Busines	,	
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e, Mar	permit. Peges 1 and 2 should be Depertment of Health and Menta Importent: If Item 27 ie marked any injury or other traumatic ev QDCB.		19a. Informant's Name/Relation RICHARD TEI 20a. Method of Disposition				19b. Maili 1407	BU	LLS	LANE	J	oppa,  OPPA,  Date	MAF		21085	-
Baltimore,	oit. Peges estment of ortent: if it injury or o		PDBurial 2 ☐ Crematic 4 ☐ Donation 5 ☐ Other 21. Signature of Funeral Servi	(Specify)	)	State	cemetery, cre ARDENS	OF	other plac FAII	TH 2	2/13	/06	BAI	TIMOR		T.
Ba	Depe Impo any ii		23a. Part1. Enter the disease	or comp	fications that ca	aused the dea		1211	CHE	ESACO	) AV	ENUE E	BALT		21237	-
68760, <	Physician be executed by sician and ettending physician and process as the burial-transit	dical Examiner	shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	a. Due to ( b. Due to ( c.		quanta of):	n ∕~							Interval Between Onset and Death Marth S	
P.O. Box 6	0 0	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 NNo 9 □ Unknown	:		irth 2 ☐ Fe ant at time of	tal death 3	⊒Ectopic p ⊒ Other (s			te e re			23d. Date of d Month	elivery Day Year	
	w requires that been signed b should be deta		Part II. Other significant cond	itions co	ntributing to de	ath but not re	sulting in the u	underlying o	ause give	en in Part I.			obacco Yes 2		to the cause of death?  Probably 4 Unknown	
al Records,	Physician: The law requires that the this certificate has been signed by the tail director, page 2 should be detach	Completed										24a. Was autor perfo 1 🗆 Yes		prior to death?		
Division of Vital	To the Hospital or Attending Physician: The lav within 24 hours effect death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	atlon; To Be	25. Was case referred to med examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Per 2 Accident inve	ı	28a. Date o		⊒ ER/Outpatie 28b. Time o Injury		28c. Injun World	er: 4 ∐ Nui ⁄at	rsing Ho	n <i>Check only d</i> me 5 ☐ Resid 28d. Describe f	dence		ecity) HOSPICE	
Divis	rs efter dei si Directo ed in by th	Certification;		ld not be imined	28e. Place	of Injury - At ng, etc. (Spec	home, farm, st	reet, factor	y, office			28f. Location ( City or Tox	Street au	nd Number or F e)	Rural Route Number,	
	the Hospital hin 24 hours e the Funeral I npletely filled	edical	one)	al Exami		isis of examir per stated	ation and/or in	westigation	, in my o	pinion, deat	th occurr	ed at the time,	cause(s date an	) and manner a d place, and du	as stated. ue to the cause(s)	
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	10	4	30. Name and address of pers	aul	ompleted cause	of death (Ite	em 23a) (Type,	Print) houle	s8t	veet,	/B	celto	M	213	04	
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			1 - For State Registrar	State	of Marylar		artment			Mental Hy	giene	16 04:	360
	Physici /Medi		1. Decedent's Name (First, Middle				Thur	MAI	V	2. Date of De Month	Day	Year 3. Time 17.	of Death
	Examir		4a. Facility Name (If not institution, The Shas Ho  5. Social Security Number	give street and no	umber) HUS/A/A 7. Age (In yrs.	last hirthday)	4b. City,	Him	ecation of De Colored Under 24 H		4c. County		or Foreign
	Funeral Director		216-48-0400 Usual Residence of Decedent	1 <b>∑</b> M 2□ F	57	Yrs.	Months		Hours M		y, Year)	S.(	c.
	the Maryla 28a-f ehow notified at	Director	Md . 10e. Street and Number	NA	10c. Cr	ty, Town or Lo	imore	Code			10g. Citizen of W		City Limits
	be filed within 72 hours after death with the Maryland ital Hygiene.  id other then "natural", or itame 23a or 28a-f ehow event, Ira Medical Exacidisat must be notified at	Funeral Di	1832 N. Colli:	12. Was Dec Armed F	cedent Ever in U		Was Deced	2121. ent of Hispa fly Cuban, i		(Specify Yes or No erto Rican, etc.)	U	SA - American Indian, k, White, etc.	
215-0036	in 72 hours a "natural", o bulcal Exar	Completed by	3 Widowed 4 Noivorced  15. Decedent  (Specify only highes	year or selection grade completed	Dates:	16a, Dece	1 ☐ Yes 2  dent's Usua kind of work DO NOT us	I Occupatio	Specify: In ing most of v	working	Specify 16b. Kind of Bu		
zız pu	o a p >	Be Comp	Elementary/Secondary (0-12)  Trade School  17. Father's Name (First, Middle, L		(1-4or 5+) Thur		Self-	Emplo	yed I. Mother's N	lame (First, Middle,	Maiden Surnam	Inproveme:	nt
	12 should and Men is marke raumatic	To	Allen  19a. Informant's Name/Relationsh  Antoinette Sine		Daughte	19b. Maili			Number or	Rural Route Numbe	er, City or Town,	State, Zip Code) 2: imore, Md	
altimore,	of He		20a. Method of Disposition  Burial 2 Cremation  4 Donation 5 Other (Sp.	3 □Removal from	State 20b. F	Place of Disponentery, cres	osition (Nam matory or ot	e of her place)		Date 16–06	20c. Location -	City or Town, State	
Balt	permit. Pag Department important: t eny injury o once.		21. Signature of Funeral Service L	g wa	Com	22	2. Name and March	F.H.	f Facility East	Balt 1101 I	timore, E. North	Md. 2120. Ave.	2
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ŭ	death certifii e attending p ad for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live	utcome of pregna birth 2 ∏ Feta nant al time of d nown	I death 3	Ectopic pre				23d. Date Mor	e of delivery oth Day	Year
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10 0	ng Phys Iter this Ineral di	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Natural 5 Pending investig	28a. Date (Mor		ER/Outpatier 28b. Time of Injury		Other: Bc. Injury at Work?	4 🗌 Nursing	Heath (Check only of Home 5 Residue)  28d. Describe h			
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	Physici	an	Decedent's Name (First, Middle, Last)	1./// / / / / /	-	77.	201	2. Date of Death Month	h Day Year	
	/Medio		4a. Facility Name (If not institution, give s	WILLIAM treet and number)	-/-	4b. City, Town, or	Location of Death	FEB.	4c. County of Dea	/ //
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	Funeral Director		5. Social Security Number 6. Sex 220-30-7354			If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, JULY 26	Year) 9. Bir	thplace (State or Foreign puntry) IRGINIA
	land ow		Usual Residence of Decedent  10a. State  10b. County	10c. City, 7	Town or Loc	cation				10d. Inside City Limits
	Mary a-fsh	tor	MARVIAND N	IA		Ka	ALTIK	ORE (	2,00	1 ⊈Xes 2 □ No
	or 28	Directo	10e. Street and Number			10f. Zip Code			og. Citizen of What C	ountry?
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036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked othar than "natural", or Itams 23a or 28a-f show othar traumatic svant, Ita Madical Examination at Itan Ma	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Year or Dates:		Vas Decedent of H Yes, specify Cuba	spanic Origin? (Sp. n, Mexican, Puerto Specify:	ecry Yes or No- Rican, etc.)	14. Race - Ami Black, Whi	
2-0036	72 ho	eted	15. Decedent's Educ (Specify only highest grade	cation	16a. Deced	ent's Usual Occup	ation during most of work	ina 1	16b. Kind of Business	/Industry
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	should be nd Mental marked o	To Be	SAMUEL	TEA	RV		MILD			RKSDALE
ary	2 shou and N Is mai		19a. Informant's Name/Relationship (Type		7	g Address (Street a			City or Town, State,	
2	1 and 2 Health am 27 thar tra		EDNA TERRY	(WIFE)	420	6 KIDG		20. BAZ	TO, MD.	21215
20	0		20a. Method of Disposition  1 Burial 2 Cremation 3 R	emoval from State		sition (Name of latory or other place			20c. Location - City or	
altimore,	permit. Pag Department Important: I any injury o		<ul> <li>4 □ Donation 5 □ Other (Specify)</li> <li>21. Signature of Funeral Service License</li> </ul>				57 02-1			MILLS, MA
B	permit. Departr Importu any inji		Va Dietich 1	V. W Illiam	20 7	DSEP	is of Facility BA	BOWN C		RAL HOME 21217
			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the death.	Do not ente	or the mode of dyin	g, such as cardiac	or respiratory arre		Approximate Interval Between
-1	Physician		Immediate Cause (Final disease or condition	Lung Can	ier					Onset and Death
B	/Medical Examiner		resulting in death)	Due to (or s a consequer	nce of):					
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V II a	Physician: Th r this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Death	1922		
ō	Phys this al di	.: To	1 ☐ Yes 2 No ''	28a. Date of Injury 28	VOutpatient 3b. Time of	3LI DOA	4 LI Nursing Ho	me Resider 28d. Describe hov	nce 6 Other (Spe winiury occurred	cify)
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Division	To the Hospital or Attanding I within 24 hours after death. To tha Funaral Director: After completely filled in by the funer	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or R. State)	ural Route Number,
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	To the Hos within 24 h To tha Fur completely	Me	29b. Signature and little of certifier	100		29c. License	number	29	d. Date signed (Mont	h, Day, Year)
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			4 101	Department of Health and M Certificate of Death	ental Hygie	711116	04362
	Physici	an	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
	/Medic Examin	cal	LAURA M. THOMPSON  4a-facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	February	4c. County of Death	1
	Exami	ler	Baltonon Washington Medi	16.	Jumsit	Anne	mundel
	Funeral Director			hday) If Under 1 Year   If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth August Day, 29	2°,1929 Mar	nplace (State or Foreign Mand
	land ow		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town	n or Location			10d. Inside City Limits
	ith the Marylan or 28a-f ehow	ctor	Maryland Anne Arundel Pa	sadena			1 ☐ Yes 2 📉 No
	th with th	<b>Funeral Director</b>	10e. Street and Number 1701 Sandbar Lane	10f. Zip Code 21122	10g.	. Citizen of What Cou	untry?
920	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Importent: If Item 27 is marked other than "naturel", or Items 23a or 28a-f show eny Injury or other traumatic event, the Medical Examinar must be notified at once.	5	11. Marital Status  1 Never Married 2 Married  3 Www. Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No if Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 🎒 No Specify:	ocity Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
5-0	natur natur	leted	(Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of workit life. DO NOT use retired)	ng 16	b. Kind of Business/li	ndustry
Maryland 21215-0036	d withir jiene. r than	Be Completed	Elementary/Secondary (0-12) College (1-4or 5+)	Homemaker		Home	;
pu	be filed tal Hyg d othe event,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name		iden Sumame)	
ryla	should of Men marke matic	ဥ	William Leroy Tayman  19a. Informant's Name/Relationship (Type, Print)  19b.	Mary  Mailing Address (Street and Number or Rura	Goeller	ity or Town State Z	in Code)
	end 2 salth ar n 27 is		Robert W. Thompson Jr (Son) 51	O South Potomac Stree			
Baltimore,	Pages 1- ient of He nt: If Iten ry or oth		TEL DUITAL & LICHERITATION 3 LINERIOVALIFOR STATE	y, crematory or other place)		c. Location - City or T kridge, Ma	
Balti	permit. Departm Importe eny inju		21. Signature of Funeral/Service Licensee	22. Name and Address of Facility McCully-Polyniak Fu 3204 Mountain Road,			
			23a art1. Enter the disease, or complications that outsed the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac o	r respiratory arrest	a, Haryrai	Approximate fnterval Between
	Physician /Medical		fmmediate Cause (Finaf disease or condition a	V 815			Onset and Death
	Examiner		Due to (or as a consequence of	a)ic con ch			
2) /	be iis	lner	Sequentially list auditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	<i>t</i> ):			
8	cate be executed physicien and the burial-transit	Examiner	resulting in death) Last  C.  Due to (or as a consequence of	of):			
8760,	ate be physicie the bur	dlcal	d				
OX 6		a)	#F FEMALE: 23b. Was decedent pregnant 23c. #f yes, outcome of pregnancy			23d. Date of deliv	/BIV
O. B	The law requires that the death certificate has been signed by the attending to age 2 should be detached for use as	Physician/M	in the past 12 months?  1 Yes 25 No 9 Unknown  1 Live birth 2 Fetaf death 4 Pregnant at time of death 9 Unknown	3 Ectopic pregnancy 5 Other (specify)		Month	Day Year
ds, P	uires that signed b	by	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
P 2	law req as beer 2 shou	Completed	Coronary antry di	jense	24a. Was an autopsy	24b. Were aut	opsy findings available ompletion of cause of
F B	rician: The lav certificete has rector, page 2	Com			performed	d? death?	2 No
كَ ڲ	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?  1 □ Yes 2 □ No  Hospital: Impatient 2 □ ER/Out	26. Pface of Death		a C COthas (Casa	4.1
しらいから Division of Vital	Attending Physic death.	tion: To	27. Manner of Death 28a. Date of Injury 28b. T	patient 3 DOA 4 Indising hon	28d. Describe how i	e 6 Other (Speci injury occurred	ny)
Divisi	I or Attendi after death. Director: A i in by the fu	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rui State)	ral Route Number,
	To the Hospital or Atlending Physician: The within 24 hours after death.  To the Funerel Director: After this certificete his completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)  Check only one)  Check only one)  Check only one)  Check only one)	death occurred at the time, date and place, a Vor investigation, in my opinion, death occurre	and due to the caus ad at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To th within To th compl	Me	29b. Signature and little of certifier	29c. License number	29d.	Date signed (Month,	, Day, Year)
	,6		m)	1748000	07	2/14/21	006
	12		30. Name and address of person who completed cause of death (Item 23a) (	Huspitz)	, C7/2	n Bour	in mD
	Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 2006  32. Registrar's Signature	mille	<i>'</i>		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 10 Setta oma Ebruary ,2006 -0 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Villa redericie Mursing Home, 7. Age (In yrs. last birthday) Home Battimore cetons ville Birthplace (State or Foreign Country) Social Security Number 8. Date of Birth (Month, Day, Year) 1□ M 20 K Days Hours 220-20-822 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Catonsvi Ma 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Blag 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Social Elementary/Secondary (0-12) Worker 12-11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3217 ctrmore Leeder -daughter 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baetmore Cemeleres 22. Name and Address | Facility 21, Signature uneral Service License Home Balto, md, 21229 Pimarch Reneral er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest head failure. List only one cause on each line. Atten Scient Sue to (or as a consequence of): Cardio Vasculas Disease Immedia e Cause (Final disease Condition resulting in death) lic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy Parkinsons 2 1 No 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner nding physician and use as the burial-transit

**Physician** 

**Funeral** 

Director

?7 is marked other than "natural", or iteme 23a or 28a-1 show traumatic event, the Medical Evanthar must be notified at

and 2 should be filed within 72 hours after ealth and Mental Hygiene.

and Mental Hygiene.

permit. Pages 1 and 2 s Department of Health ar important: If item 27 is any injury or other trau once.

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Records,

Division of Vital

/Medical

Completed by Physician/Medical Examiner Be 2 After thi funeral Certification:

27. Manner of Death

State

within 24 hours after death. To the Funeral Director: A

(Check only one) 29b. Signature and attle of certifier

29a. Certifier

1 ☐ Yes 2 🔼 No

1 Natural

2 Accident

3 Suicide

4 Homicide

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

5 Pending investigation 6 ☐ Could not be

28a. Date of Injury (Month, Day Year)

1 Inpatient

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 TYes 2 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

29c. License number D21649

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wekens Aut. Salhmore MO 21228 AMBANDAM BASKALON- 345J

Hospital:

31. Date filed (Month, Day, Year) FEB 1 5 2006

32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

2 ER/Outpatient 3 DOA

28b. Time of

State of Maryland / Department of Health and Mental Hygiene State Registrar<mark>Amend Item #2 Per PHY C852 29 Tiff Cate por Death</mark> 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **09** Year **Physician** BONNIE tehruary to 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death Columbia Howard Howard County General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1□M 2□F Yrs. 86 Director 275-16-7266 April 27, 1919 West Virginia Usual Residence of Decedent 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits 1 Yes X No Director Marvland Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21042 U.S.A 9898 Frederick Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 ▼ No Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Ivv Oldaker Llovd Earl Kirkpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 859 Snowfall Way Westminster, Maryland 21157 Ms. Carolyn Bender Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) 02/13/2006 Clarksville, Maryland Columbia Memorial Park Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Part 1. Enter the disease, or conshock, or heart failure. List only Brain stem Centro Vascular Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last by Physician/Medical Examiner attending physician and for use as the burial-transit Immune Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Year Month Day 4 Pregnant at time of death 5 Other (specify) 9 Haknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 TYes 3 ☐ Probably 4 ☐ Uлклоwn Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2□ No 1 Yes 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one Hospital: Other: 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Diractor: After th 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 | Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 30641 Name and address of person, who completed cause of death (Item 23a) (Type, Print)

Rame (h Sahapa M' 201-109 Back River Neck Road Bal 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 5 2006 Registrar

Gloria Tabron Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,27,28a-f.pen/e.g853,3/10/06 TT State of Maryland? Department of Health and Mental Hygiene 06-0874 AKG Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Month Year **Physician** GLORIA TABRON February 4, 2006 10:17/Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Loch Raven

If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Baltimore County 1032 Deanwood Road 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Hours 54 Yrs. Director Virginia 216-78-3873 June Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Baltimore Md. 1 XYes 2 No Director 28a-f 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? ò USA 21234 1032 Deanwood Avenue Apt. T-1238 Be Completed by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 전 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or itama 11. Marital Sfatus 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black 3 Widowed 4 Divorced "naturel", 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home-Maker Domestic permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Importent: if item 27 is marked other th
any injury or other traumatic event. Ital 12th None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Annie L. Stokes Tabron Willie 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code)
4 Dowling Cir.T2, Baltimore, Md. 21234 19a. Informant's Name/Relationship (Type, Print) Jacqueline S. Smoot (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Riverdale Pk.Crematory 2/10/06 Riverdale, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 108 W. North Avenue, Baltimore, Md. 21201 James E. Lincoln Funeral Home PA 23a Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Narcotic (Methadone) Intoxication /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner or Attending Physician: The law requires that the death certificate be executed burial-transli resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760 Medical Certification; To Be Completed by Physician/Medical E P use as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year 4⊡Pregnanf at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? Yes 2 🗆 No 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 120 ther (Specify) at scene 1XXYes 2 □ No 1 Inpafienf 2 ER/Outpatient 3 DOA ijŝ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury af Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 Yes 2√ No within 24 hours after death.

To the Funaral Director: A completely filled in by the fu Fnd 2/4/2006 Fnd 10:15A<sup>M</sup> 2 Accident 6 Could not be 28e. Place of Injury - Af home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number of Rural Route Number City or Town, State) 1032 Deanwood Road C #1, Loch Raven, Md determined 4 Homicide Apartment To the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier February 5, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 HE DOONE

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

5 2006

3 Gegisfrar's Signature

			1 = For State Registrar	State of M	larylan		artmer rtificat			and M	ental Hy	giene Reg. No.	006	0 3	66
Φ,	Physici	an	Decedent's Name (First, Middle, Lass     Wiley Tallman	t)							2. Date of Domestin	eath Day 8	2006	3. Time o 5:41	
· A	/Medio Examin	4.0	4a. Facility Name (If not institution, give Howard County Genera		)			Town, or umbia	Location o	of Death			County of Dear	th	
	Funeral		5. Social Security Number 6. S		ge (In yrs. 1	ast birthday) Yrs.		1 Year Days	If Under 2	24 Hrs. Min.	8. Date of Bi (Month, D 4 26	irth	9. Bin	hplace (State ountry) ennessee	
7	Director		Usual Residence of Decedent		10c Cib	, Town or Lo	anation .							10d. Inside C	City Limits
	Maryla f ahov ied at	ļo	Maryland Howard			umbia	ocation								2 □ No
	or 28e-	Funeral Director	10e. Street and Number		001	dilibita	10f. Zij						en of What Co	1.	
	e 23a	erai [	10217 Owen Brown Road	12. Was Deceden	t Ever in II	S 13	Was Dece	21044	spanic Orio	gin? (Sp	ecify Yes or N		A Race - Ame		
980	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "naturel; or Iteme 23s or 28s-f ahow other treumatic event, the Medical Examiner must be notified at	ρ	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	Armed Forces  1 Yes 2  If Yes, Give  Year or Dates	? ] No		If Yes, spe	cify Cuba	Specify:	i, Puerto	Rican, etc.)		Black, Whit	e, etc.	
21215-0036	hin 72 ho In "natur Medical	Completed	15, Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)		5+)	16a. Dece (Give life.	dent's Usu kind of wo DO NOT u	rk done d	furing most	t of work	ng	16b. Kin	d of Business	/Industry	
21	ygiene ygiene her tha		12	4			Bookk	eeper	18 Mothe	ar's Name	e (First, Middl		Estate		
Maryland	uld be fil Mental H nrked oti	To Be	17. Father's Name (First, Middle, Last) David Tallman						C1	ara A	rnold				
Man	nd 2 sho lith and l 27 is ma r treuma		19a. Informant's Name/Relationship ( Carylon J. Tallman/w								a <i>l Route Num.</i> ab <b>ia,</b> Mar		Town, State, 21044	Zip Code)	
nore,	ages 1 and of Heam 1: If Item		20a. Method of Disposition 1		e c	lace of Dispo emetery, cre	matory or	other plac			2006		eation - City or		
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than 1 any Injury or other treumatic event, than 8006.		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Fleck Funeral Home  7601 Sandy Spring Road Laurel, Maryland 2												
1		-	23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	ed the deat									Approxima Interval Be	etween
Fa.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	aAthero:	sclorot	ic Card	liovaso	ular	Diseas	е				Onset and years	Death
	Examiner			Due to (or a											
W	d ansit	ımlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or a	is a conseq	uence of):									
8760,	certificate be executed rding physicien and ise as the burial-transit	al Ex	resulting in death) Last	Due to (or a	is a conseq	uence of):									
9	ntificate ng phy as the	Medic	IF FEMALE:	0.											
.O. Box	ath	Physician/Medical Examiner	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcom 1 Live birth 4 Pregnant 9 Unknown	2 ☐ Feta at time of d	death 3	⊒Ectopic p □ Other (s					2	3d. Date of de Month	livery Day	Year
4	equires that the de sen signed by the a tould be detached to	þ	Part II. Other significant conditions of	ontributing to death	but not res	ulting in the u	underlying	cause giv	en in Part I	l.				o the cause of robably 4	death? ]Unknown
Records,	W S S	Completed									per	is an opsy formed?	prior to death?	utopsy tindings completion of s 2 \( \text{No} \)	s available cause of
Vital		BeC	25. Was case referred to medical examiner?						26. Place	e of Deat	h (Check only		10.10	2 2 110	
of <	Physicien: this certific ral director,	2	1 Yes 2 No	Hospital: 1 Inpa		ER/Outpatie			4 🗀 🕅	ursing Ho	me 5 ☐ Re		Other (Spe	ecify)	
ion	ending I sath. or: After he funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	( <i>Month</i> , <i>L</i>	Day Year)	Injury	M	28c. Injur Wor 1 🗌	k? Yes 2□	No					
Division	al or Att	Certification:	3 Suicide 6 Could not b 4 Homicide determined	286. Place of	Injury - At he etc. (Specif	ome, farm, si (y)	treet, facto	ry, office				(Street and own, State)		Rural Route Nu	m <i>ber</i> ,
	To the Hospital or Attending Physimiting 24 hours after death.  To the Funerel Director: After this completely filled in by the funeral di	edical (	29a. Certifier 1 🕅 Certifying Pl (Check only one) 2 🗍 Medical Exam	nysicien: To the be miner: On the basis and manner	of examina	owledge, dea ation and/or in	th occurre nvestigatio	d at the tir	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time	e cause(s) e, date and	and manner a place, and du	s stated. e to the cause	(s)
	To the To the Complex	Me	29b. Signature and tytle of certifier				29	c. Licens	e number			29d. Dat	e signed (Mor	ith, Day, Year)	
	0		1 ta	no	6 deat //s-	- 72e) (To -		51860				2/13/	2006		
	12		30. Name and address of person who Jonathan Fish MD 10	completed cause o 700 Charter				, Mar	yland	2104	4				
	St. Regist	ate rar	31. Date filed (Month, Day, Year)	32/Regi	strar's Signa	ature	radi s								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 8:40 AM TARRANT FER ZOCK VEOLIA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner BALTIMORE UNIVERSITY MARYLAND OF-If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday).
Yrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** Days Hours 1 M 2 F 219-10-9770 Usual Residence of Decedent Director permit. Pages I and 2 should be filed within 72 hours atter death with the Marylan Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene I have the Transfer of th 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No Completed by Funeral Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) rivate 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (niece) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balto. Md 15. Rosalie Dawkins Johnson lamer 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Qate 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 2012006 Arbutus Mem.P 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph L. Russ Funeral Home, P. A 2222 W. North Ave. Batto. Ma. 217 23a. Parti Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 15 WEEKS MRSA GNOCLARDITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No this certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier P 19749 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 GREENE MD Sowal 51 Ms 31. Date filed (Month, Day, Year) 32 Registrar's Signature State FEB 1 5 2006 Registrar

			1 - For State Registrar	State of Ma	-		tment ificate			and M		iene	0.0	6	04	368
	Physici	- 5	1. Decedent's Name (First, Middle, Las John J. V	illa							2. Date of Dea Month Februar	Day	, 20	Year 006		of Death
	/Medio Examin	_		lvd.			<sub>46. Сіту,</sub> т В <b>а1ti</b>	mor	e			Ba	County o	ore		
	Funeral Director		210-20-2303	9X 7. Age	95 Y		If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Birth (Month, Day June 24	, 19	10	9. Birthol Count Mary	ace (State try) / Land	e or Foreign
	B Maryland a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County  Md. Baltimor	e	10c. City, Town									10		City Limits as 2 No
	h with the 23a or 28 let be no	Funeral Director	10e. Street and Number 8800 Walther Bl	vd.			10f. Zip C 2123				1	0g. Citiz US		hat Coun	try?	
036	J within 72 hours after death with the Maryland ilene. The Macical Examinational be notified at the Macical Examinational be notified at	by	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give X Year or Dates:		If Y	as Decede res, specif	y Cubai	spanic Origin, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)			, White, e	an Indian, etc. nite	
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gaitimore,	S + 0		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □  4 □ Donation 5 □ Other (Specify	′)	20b. Place of cometery	op S	tory or oth ervi	er place ce C	0. 2	2-20-	-06	Tow	son,	ity or To		
g	permit. Pege Department of Important: # any injury or		21. Signature of Funeral/Service Licen				T05	UYO	ork K	<b>a</b> . 1	eral Hor owson, I	√ld. i	Inc. 2120	4		
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or common shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. Phe Due to (or as a	e.	f):						est,			Approxim Interval B Onset an	etween d Death
8/60,	icate be executed physician and the burial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		vat ( a consequence of a consequence of		lan	A	cci	ent					29	Cani )
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ς, Γ	w requires that the been signed by the should be detache	þ	Part II. Other significant conditions o	ontributing to death bu	it not resulting in	the und	erlying cau	ıse give	n in Part I.		23e. Did to	,	_			f death?
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DIVISION	el or Attending Phisatter death. I Director: After this In by the funeral in	Certification:	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be			jury	М		at ? ′es 2 □ l	No	28d. Describe h					
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	To the Hospitel or within 24 hours at 50 the Funeral D completely filled in	Medical	(Check only one)  2   Medical Examone)	niner: On the basis of and manner sta	examination and	Vor inve	stigation, i	n my op	e, date an inion, dea number	th occurr	ed at the time, d	ate and p	olace, ar	nd due to	the cause	
)	IM O	_	Wellin m	Jussel	M		D	30	18	7			-		200	
-	1282 /		30. Name and address of person who	completed cause of de				81	1	Bal	time of	UP	2 (2	34		

DHMH 17 Rev 1/2001

State Registrar

31. Date filed (Month, Day, Year) FEB 1 5 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene-1 - For State Ragistra Certificate of Death Rag. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** February 9, 2006 Catherine W. 3:45 a <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Pickersgill Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth Nov. 24, 1914 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □ M 2 🔀 F 91 MaryTand 215-40-0189 Yrs. Director Usual Residence of Decedent 10b. County 10c. City, Town or Location ral', or Items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes **2**/☐ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 615 Chestnut Avenue 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, If e Madical Exercities, one. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 💢 No Specify: White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Clerk Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin Elizabeth Edmunds 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3235 Kensington Court Manchester, Md. 21102 Catherine Murkey / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State WBurial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 2/11/2006 Dulaney Valley Cem. Timonium, Maryland 21. Signatur of Funeral vivi Lice es 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md21204 as complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final Physician Ma Inutrition wee KS disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** ebilit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner sician and burial-transit O teo Drosis Due to (or if a consequence of): as the burial Box 68760. IF FEMALE: for use a 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Dav 4☐Pregnant at time of death 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, IVC 1 ☐ Yes 2 1 To 3 ☐ Probably 4 ☐ Unknown Dulmonaly Be Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1□ Yes Hospital or Attanding Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Aatural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061199 Stee un () 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 North Charles St, Suite 203. Touson, MD 13/ac . Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 5 2006 Registrar

			For State Registrar		State	of Maryla		artmen rtificat					giene Reg. No.	006	04370
			1. Decedent's Name	(First, Middle,	Last)					-		2. Date of De.	ath		3. Time of Death
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			Usual Residence of									may 11	, -,		111
	ehow		10a. State	10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	a-f-e	ctor	MD	Bal	timore		Gwynr	0ak							1 ☐ Yes 2√ No
	or 28	Director	10e. Street and Num	per				10f. Zip	Code				10g. Citiz	zen of What Co	ountry?
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			shock, or heart Immediate Cause (F	tailure. List or	ly one cause on	each line.									Interval Between Onset and Death
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0			27. Manner of Death	• C Paradia	28a. Date	of Injury oth, Day Year)	28b. Time of Injury	2	8c. Injury Work			28d. Describe h			77.000/
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	rs afta el Dir	Cer										,	,,		
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8:00 PM

VURELA, ANNA 2-12-06

Division of Vital Records, P.O. Box 68760,

			For State Registrar		State o	f Marylan	-	artment of H				giene leg. No.	16	04371
	Physici	an	Decedent's Nam								2. Date of Dea Month	Day	Year	3. Time of Death
	/Medio	al	Mary			liams		4b. City, Town, or	Lagation	of Dooth	02	13 2 4c. County	200 6	10/19 AM
	Examin	er	percu.	-6	give street and nu	tosnit	01	ROCE	dal	O		30	1+1111	010
	Funeral		5. Social Security N		6. Sex	7. Agg (In yrs.	last birthday)	If Under 1 Year	If Under		8. Date of Birth	Your)	9. Birthpla	ace (State or Foreign
- 1	Director		214-20-9	210	1 □ M 2 💢 F	7	9 Yrs.	Months Days	Hours	Min.	February,	17926	Mary	/land
	pug 🛦		Usuaf Residence of 10a. State	f Decedent 10b. County		10c. Cit	y, Town or Lo	ocation					10	d. fnside City Limits
	Aaryla f •ho	٥	MD	,	timore			Hill						1 ☐ Yes 2 No
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		ıner	11. Marital Status		12. Was Dec	edent Ever in U	.S. 13.	Was Decedent of H	ispanic Ori in, Mexicar	igin? (Spe	cify Yes or No- Rican, etc.)	14. Rac Blac	e - America ck, White, e	
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Ba	permit. Pages Department of t Important; if Its any injury or or		21. Signature of the	111	WITTE	11111 G. L		050 York				21 204	. ar , , c	Jile, 210.
	Pnysician		23a. Part1. Enter t shock, or hea fmmediate Cause disease or condition	art failure. List (Final	complications that conly one cause on e	aused the deat each line.	h. Do not ent	er the mode of dyin	g, such as	cardiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		aDue to	(or s a conseq	uence of):							
- 1	- Author	-	Sequentially list co	onditions,	b. Due to	or as a conseq	uence of):				_			
	uted d ansit	Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events	erlying hijury	. As	cites							- 04	
ó	sicien and burial-transit		resulting in death)	Last	. Due to	(or as a conseq	uence of):							
8760,	9 3 9	dicai			d									<u></u>
9 ×	leath certifica attending ph I for use as th	/Me	IF FEMALE:		23c. If yes, ou	tcome of pregna	ancy					23d Da	te of deliver	v
Вох	death atten	Physician/Med	23b. Was deceden in the past 12 1 Pyes 21	months?	1□Live t 4□Pregr	ointh 2 ☐ Feta nant at time of d	death 3	Ectopic pregnancy Other (specify)						Day Year
P.O.	that the de led by the a detached t	hys	9 Unknown		9□ Unkn _	own						1		
Š,	res that igned t be det	þ	Part II. Other signi	ficant condition	ons contributing to d $\mathcal{M} = \mathcal{M}$	4	ulting in the u	nderlying cause give	en in Part I		23e. Did to	V		e cause of death?
oro	w requir been si should I	Completed	11 .	+	Melli	TUS	-/-	PE_L			-			
Rec	The taw ate has t page 2 s	Idm	Hype	rien	SICH						24a. Was a autops perfor	med?	prior to com death?	sy findings available inpletion of cause of
la l	ician: Th certificate rector, pag		25. Was gase refer	' 5 5 1 6 1	1.				26 Place	of Death	1 ☐ Yes Check only or	/ -	I□Yes 2	2∐ No
<u>≥</u>	yelcian: is certific director,	To Be	examiner?	(No	Hospitaf:	fnpatient 2	ER/Outpatier	nt 3 DOA Oth			ne 5□Reside		er (Specify)	,
0	ding Phys h. After this funeral di		27. Manner of Cal	th 5 🗆 Pendin	28a. Date	of Injury th, Day Year)	28b. Time o	f 28c. Injun Worl	v at k?	1	28d. Describe h	ow injury occur	red	
S.	uttendin death. ctor: Afi y the fur	cati	2 ☐ Accident 3 ☐ Suicide	investig 6 □ Could r	jation	77.			Yes 2		206 1	4 A of Al		G
Division of Vital Records,	after of Direction by	Certification:	4 Homicide	determ	ined 286. Place	of finally - At hing, etc. (Specif		reet, factory, office		•	28f. Location (S. City or Tow		er or Hurai	Houte Number,
	To the Hospital or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edicai C	29a. Certifier (Check only one)	1 Certifyin 2 Medical	g Physicien: To the Examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat tion and/or in	h occurred at the tin vestigation, in my o	ne, date an pinion, dea	d place, a	and due to the c ed at the time, d	ause(s) and ma ate and place,	inner as sta and due to	ited. the cause(s)
_	To the within 2 To the complet	Me	29b. Signature and	title of certifier	1			29c. Licens			1	9d. Date signe		
	0	_	· a	mondo	-			000	5863	31	F	EB 13	200	2
_	10		30. Name and add	ress of person	who completed caus	se of death (Iter	n 23a) (Type,	Print)  111 Squa		4	D 11		10	2.0
/	Sta	te	31. Date filed (Mon	oth, Day, Year)	1111100.	1000 F	ature &	in Syna:	re i)r	ive.	5altin	ore p	11) 0	417-31
	Registr	ar	F	EB 15	2006	me S	100	Sel.						

VILSON

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Year **Physician** 9:03 PM FEB 2006 08 /Medical Kenneth Calvin Wilson 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE GOOD SAMARITAN HOSPITAL Baltimore City

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth (Month, Dey, Yeer) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1**X**]M 2□F Director 217-10-1084 85 04/30/1920 Maryland Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c, City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event, It a Medical Examinant for institutional. 1 ☐ Yes 2 ☑ No Director Baltimore Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 3216 Taylor Avenue U.S.A. 14. Race - American Indian, Funeral 21234 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 [X]No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Cottege (1-4or 5+) 9 Purolator Industry Dispatcher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Roy Calvin Wilson Margaret Elaine Dawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1406 North Stepney Road - Aberdeen, Maryland 21001 ce of Disposition (Name of Date 20c. Location - City of Town, State Santo J. Battaglia (son-in-law) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) 02/13/2006 Baltimore, Maryland Parkwood Cemetery 21. So hat re of Funeral Service Licenses 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Lucthon 11750 Belair Road - Kingsville, Maryland 21087 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final Physician WK. disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner DEHYDRATION WK Sequentially list conditions, if any, leading to immediate causa. E. if a Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): SICIAN P.O. Box 68760 Physician/Medical as the attending phys IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy jo in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown signed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. by pe CHRONIC OBSTRUCTIVE PULMONARY 1 Yes 2 No 3 Probably 4 Unknown DISEASE Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No DEMENTIA autopsy performed: 1 Yes ₽ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 patient 2 ER/Outpatient 5 3 DOA 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: After the Hospital or Attending Natural 5 Pending 1 □ Yes 2 □ No death. investigation М 2 Accident in by the f within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M.D. FEB, 08, 2006 RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, BALTIMORE, MD

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

1 5 2006

Registrar's Signature

		Amend item#17,18,perFH 1 - For State Registrar	(652,2/22/06 TI State of Marylar	id / Depai	tment of ificate of	nealli and i	vientairiyg	giene 199. 2006	04373
Physicia /Medic		Decedent's Name (First, Middle, Last)     Rachel Hodge Will					2. Date of Dea Month FED	Day Yes	06 4:05 AM
Examin Funeral	er	5. Social Security Number 6. Sex	treet and number)  alof Baltin  7. Age (In yrs.  84	かりて	4b. City, Town,  If Under 1 Year  Months Days			4c. County of D  N/A  (Year) 9.	Birthplace (State or Foreign Country)
Director		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ty, Town or Loca			Mar, 03	, 1321	10d. fnside City Limits  1¥Yes 2 □ No
with the Ma a or 28a-f	Funeral Director	Md. N/A  10e. Street and Number  3637 Cottage A	Ave	ltimor	10f. Zip Code	21215		10g. Citizen of What	t Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itame 23a or 28a-f show any injury or other traumatic event, the Madical Examinar must be notified at once.	þ		2. Was Decedent Ever in U Armed Forces? 1		as Decedent of Yes, specify Cu	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	Black, V	American Indian, Vhite, etc. Black
vithin 72 hound.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give ki		upation s during most of work ne work		16b. Kind of Busine	•
uld be filed w Aental Hygier rked other ti	To Be Col	8th 17. Father's Name (First, Middle, Last) Henry Martin Hoo	lge William I		DI, 11		ne (First, Middle,	Maiden Surname)	oorp.
1 and 2 should leath and Menter is market traumatic	•	19a. Informant's Name/Relationship (Type Panthea Wilson / 20a. Method of Disposition	Daughter	-	Cottag			r, City or Town, State  ore, Md.  20c. Location - City	, 21215
permit. Pages Department of I Important: if Iti any injury or o		1  Surial 2 Cremation 3 Re 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Lineses	emoval from State Md	. Nati	onal Name and Add	fem. 2/1 ress of FacilityCh	atman-H	arris F	Maryland uneral Home ore,Md 2121
Physician /Medical Examiner butter be executed butter transit transit transit transit properties the prize transit butter	icai Examiner	23a. Part Enter the Isease, or complication of heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	PNEVMON  Due to (or as a consecution of the consecu	Quence of): WEL OF	STRUC-				Interval Between Onset and Death
that the death certificate bed by the attending physic detached for use as the b	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. ff yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	afdeath 3□E	Ectopic pregnan Other (specify)	су		23d. Date of Month	f delivery Day Year
w requires that is been signed by should be deta	by	Part If. Other significant conditions con		sulting in the und	derlying cause o	given in Part I.			te to the cause of death?  Probably 4 20 Unknown
The law re sete has bee page 2 sho	Completed	SEIZURE DISORD	DER				24a. Was autop perfor 1 Yes	rmed? prior deat	e autopsy findings available r to completion of cause of th? Yes 2 \sumbox No
	Certification: To Be	27. Manner of Death  1	ospital: 1 ☐ Inpatient 2 28a. Date of Injury (Month, Day Year)  28e. Place of Injury - Al h	ER/Outpatient 28b. Time of Injury	28c. ing W M 1[	ther: 4 Nursing Fury all ork?	28d. Describe h	dence 6 Other (	Specify) or Rural Route Number,
To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	cai Certi		building, etc. (Speci sician: To the best of my kn er: On the basis of examin	ify) owledge, death	occurred at the	time, date and place		cause(s) and manne	
To the Hi within 24 To the Fi	Medicai	29b. Signature and title of certifier	and manner stated.	and and	29c. Lice	nse number 00 61959		29d. Date signed (A	Month, Day, Year)
)		30. Name and address of person who co	2401 W.	BELVEDE	RE AVE	. BALTIM	ore MD		
Sta Registr		31. Date filed (Month, Day, Year) FEB 1 5 2006	2. Registrar's Sign	ature	be				

			For State Registrar	State of Maryland / Depa Cer	artment of Health and N tificate of Death	lental Hygier Reg. 1	2000	04374
			Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death
	Physicia		Oscar Nelson We	eller, Sr.			13, 2006	7:40 A M
	/Medic Examin		4a. Facility Name (If not institution, give stre		4b. City, Town, or Location of Death		4c. County of Death	
			Harford Memorial	Hospital	Havre de Grace		Harfor	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	ff Under 1 Year   ff Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Ye.	9. Birth Cou	place (State or Foreign intry)
	Director		234-01-9698	1 2□ F 87 Yrs.		July 11,	1918 West	Virginia
	and *	1	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	cation			10d. fnside City Limits
	Aaryli Poho	ō	M	Dol Niv				1 ☐ Yes ZX No
	28a-	Director	Maryland   Harford 10e. Street and Number	Bel Air	10f. Zip Code	10g.	Citizen of What Co	untry?
	With Mith		555 South Atwood Ro	pad Apt. 320	21014		USA	
	death ms 2;	Funeral		. Was Decedent Ever in U.S. 13. \	Was Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - Amer	
ယ	or les	필	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2 TNo	f Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 অNo <i>Specify:</i>	nican, etc.)	Black, White	, etc.
ğ	ral', o	5 D	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 1 1 1 3 2 <b>3</b> 110 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			White
5	within 72 hours effer death with the Maryland ene. Then "natural", or Items 23e or 28e-f ehow the Madical Examinar must be nutitied at	Completed	15. Decedent's Educa (Specify only highest grade of	completed) (Give	dent's Usual Occupation kind of work done during most of work		. Kind of Business/I	ndustry
7	hen 'ithin	mp	Elementary/Secondary (0-12)	Coflege (1-4or 5+)	DO NOT use retired)	т	aw Enford	romont
2	iled v lygie ther t		12 17. Father's Name (First, Middle, Last)	Guard	18. Mother's Nam	e (First, Middle, Maid		zenenc
and	d of o	Be	Cyrus Washington	Weller	Ella	May Maxel	1	
Maryland 21215-0036	houted Me	ဥ	19a. Informant's Name/Relationship (Type		ng Address (Street and Number or Ru			ip Code)
ĕ	treu		O. Nelson Weller		Linwood Ave., Bel	Air, MD 2	1014	
ē,	permit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Depertment of Health and Mentle Hygiene. Inportant: If item 27 is marked other than "natural; or items 23a or 28a-1 show any injury or other traumatic event, the Madical Examinar must be nutified at once.		20a. Method of Disposition	20b. Place of Dispo	sition (Name of matory or other place)	Date 20c	Location - City or	Town, State
Ë	Pege ent o nt: If ry or		1 ☐ Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	14-06 To	wson, Mar	vland		
Baltimore,	Derta	1	21. Signature of Funeral Service Licensee					
ä	a a E a		teller Clare	de .	Name and Address of Facility MCCOMAS Funeral H 1317 Cokesbury Ro	ad, Abingd	on, Mary	and 21009
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one	ations that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Pnysician	Q 4	Immediate Cause (Final disease or condition	UMPONIC WENAL	Mune			Onset and Death
	/Medical		resulting in death)	Du- to (or as a consequence of :				
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	k =	la la	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (has a consequence of):	Manac			
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687	10	edical	d.					
Box	eath certific ettending p for use as	Z	IF FEMALE: 23b. Was decedent pregnant 23c	c. If yes, outcome of pregnancy	7e		23d. Date of def	ivery
ă	death s ette d for	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of death 5 [	□Ectopic pregnancy □ Other (specify)		Month	Day Year
P.O.	by the	Physician/Me	9 ☐ Unknown	9☐ Unknown				
	iw requires that s been signed to should be det	by P	Part II. Other significant conditions contr	ibuting to death but not resulting in the u	inderlying cause given in Part I.			the cause of death?
ğ	requires een sign hould be	ed	1761.614 UNDINE	ריקומוושוריי		1 🗆 Yes	2 No 3 Pr	obably 4 🗹 Unknown
ပ္ပ		ple	· ·	.,		24a. Was an autopsy	prior to 0	topsy findings available completion of cause of
<u> </u>	The ete h page	Completed				performed 1 ☐ Yes 2 ☐		2□ No
/ita	Physician: Th rthis certificete ral director, pag	Be	25. Was case referred to medical examiner?	anitati — J	Other	th (Check only one)		
5	Z 20	2	1 Yes 2 No	spitaf: 1 Inpatient 2 ER/Outpatient 28a. Date of Injury 28b. Time of	nt 3L DOA 4L Nursing F	ome 5 Residence		cify)
Division of Vital Records,	After funer	lo l	1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	of 28c. fnjury at Work?  M 1 ☐ Yes 2 ☐ No		, , , , , , , , , , , , , , , , , , , ,	
i <u>s</u>	Attending r death. ector: After by the fune	licat	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, st		28f. Location (Stree	t and Number or Ru	ural Route Number,
ĕ	after Dire	Certification:	4 Homicide	building, etc. (Specify)		City or Town, S	tate)	
	To the Hospital or Attending Ph within E4 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier 1E Certifying Physic	clam: To the best of my knowledge, deal	h conumed at the time, data and place	and due to the caus	e(s) and manner as	s stated.
	n 24   n 24   he Fu sietely	ledical	(Check only 2 Medical Examine one)	or: On the basis of examination and/or in and manner stated.				
	To the within 2 To the complet	ž	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Mont	h, Day, Year)
			+ He sup sian		14041		417/00	
	11		30. Name and a dress of person who com	rpleted cause of death (ftem 23a) (Type	Print) AV2 MOE	W0 2	1008	
			31. Date filed (Menth, Day, Year)	7 7 VWII	VII TITLE	7 11	1	
	St: Regist	ate rar	FEB 1 5 2006	A Asid	9			
	3			The state of the s	<u> </u>			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** February 40 2006 Walter Winiarsk 732 A /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Rossville Baltimore Co. Franklin Square Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **№** M 2 F Yrs Director 76 20,1930 217-26-6457 Jan. Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location r than "natural", or Itema 23a or 28a-f ahow the Medical Examinar must be notified at Middle River 1 Yes 2X No Maryland Baltimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3547 Buckboard Lane 21220 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [XYes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced White 1951-53 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Sanitation Foreman Baltimore Co. 6 Years avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be t of Health and Mental Caroline Bartos Edward I. Winiarski other treumatic 2 19a. Informant's Name/Relationship (Type, Pnnt) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3547 Buckboard Lane Middle River, MD 21220 Mrs. Nancy L. Winiarski (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ⊠Burial 2 □ Cremation 3 □ Removal from State ŏ Department of Important: If any injury or 4 □ Donation 5 □ Other (Specify) Garrison Forest V.A. Cem. 2/15/2006 Owings Mills, MD permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovascular Disease **Physician** a Arteniosclerotic disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner or Attanding Physician: The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No should be detached 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy After this certificate 1 Yes 2 No 1 TYAS To the Funerel Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospitaf: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DDA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide after Hospitel within 24 hours a To the Funerel ( 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated 5 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) Trimble Hill CT. Lutherville, MD 21093 MiLi Tello Phil: 6 31. Date filed (Month, Day, Year) 32. egistrar's Signature FEB 1 5 2006 Registrar

			For State Registrar	8	State of	Marylar	nd / Depa <i>Cei</i>	artmen rtificat				lental H	ygier Reg. N	000	0	4376
			Decedent's Name (First, Midd	lle, Last)								2. Date of D		Day Y	'ear	3. Time of Death
	Physici /Medi		John	Ja	mes	40	Ung					if E.F		190 ZO		7-30P M
	Examir		4a. Facility Name (If not institution	on, give stre	et and num	ber)	0	4b. City,	Town, or	Location	of Death		4	4c. County of	Death	
			Multi-Medica	al Cer	nter				owso						timo	ore
	Funeral Director		5. Social Security Number 277–20–9688	6. Sex	1 2□F	. Age (In yrs.	last birthday) Yrs.	If Under Months	1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of B (Month, D April	irth Day Yea 14,	1924	Birthpl Count Onic	ace (State or Foreign try) 1
	and w		Usual Residence of Decedenl  10a. State 10b. Count	v		10c. Cir	ty, Town or Lo	cation							10	Od. Inside City Limits
	Aarylan I show	5		Ltimo:	ce		Baltim									1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number					10f. Zip	Code		<u>.</u>	-	10g. (	Cilizen of Wh	al Count	trv?
	with 3a or		2727 Waldor	Drive	9				1234					U.S.A		,
	ms 22	Funeral	11. Marital Status		Was Deced	lent Ever in U	.S. 13.1	Was Deced	dent of His	spanic O	rigin? (Spe	ecify Yes or N Rican, etc.)	lo-	14. Race -		
36	be filed within 72 hours after death with the Maryland ital Hygiene. did other than "naturel", or ttams 23e or 28e-1 show evant, the Medical Evantiner must be notified at	by Fun	1 Never Married 2 Ma		Armed Ford 1 Yes, Give Year or Dat	2 □ No WW	TT	fYes, spec 1 ☐ Yes		Specify		Rican, etc.)		Black, Specify:	White, €	nite
ò	2 hou	ted	15. Decede				16a. Deced	ient's Usua	al Occupa	tion			16b.	Kind of Busi	ness/Ind	ustry
715	7 nin 7	ple	(Specify only high Elementary/Secondary (0-12)	est grade o	ompleted) College (1-	4or 5+)	(Give	kind of wo DO NOT us	rk done di se retired)	<i>uring</i> mo	st of worki	ng				
212	filed withi Hygiene. Ither than	Completed	12		College (1-	····	Ele	ctric	al E	ngin	eer		F.	iltrat	ion	Systems
р	al Hygi al other	BeC	17. Father's Name (First, Middle											en Sumame)		
yla	should be f and Mental I s markad of umatic eva	2		mond		oung	1				ude	Mae		Arth		
Maryland 21215-0036			19a. Informant's Name/Relation Amv M. Rohrs-0					•				.more,		or Town, St. <b>2123</b> 4		Code)
	of Health item 27		20a. Method of Disposition	adagiii	-	20b. F	Place of Dispo	sition (Nan	ne of			ate	-	Location - Ci		vn, Slate
Baltimore,			1 ☐ Burial 2 ☐ Cremation 1 ☐ Donation 5 ☐ Other (	3 □Rem	oval from S	iate	cemetery, crer lanev			"	2/1	5/06	Т	imoniu	m. M	1D
#	그 든 뿐 글		21. Signature of Funeral Service							s of Facil			1	Funera		
ä	Department Department Important in Suny in Sunce		> ///ll					1050	York	Rď.	, Tou	uson, N	1D	21204		
			23a. Part1. Enter the disease, of shock, or heart failure. Lis				h. Do not ent	er the mod	e of dying	, such as	s cardiac o	r respiratory	arrest,		1	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				TATI	<i>C.</i>	PR	cos	TAT	E CA	an c	ER		Onset and Death
	/Medical		resulling in death)	a		r as a conseq										
	Examiner	_	Sequentially list conditions,	b												
	ed ssit	line	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹	Due to (o	r as a conseq	juence or):									
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c	Due to (o	r as a conseq	juence of):				<del></del>				-	
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687	ficate g phy s the	edic		u												
Вох	eath certific attending p	N/M	IF FEMALE: 23b. Was decedent pregnant	23c.		ome of pregna		Te						23d. Date of	of deliver	у
m.	death e atte	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No		4 Pregna	th 2 □ Feta nt at time of d		JEctopic pr ] Other (sp						Month		Day Year
P.0	at the de by the tached	hys	9 Unknown		9□ Unknov	vn										
ŝ	The law requires that the death centificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Dther significant condit	ions contrib	outing to dea	th but not res	ulting in the ur	nderlying c	ause give	n in Part	l.					bly 4 Unknown
ord	w requir been si should	ted				-							res			
Records,	e law has b	Completed										24a. Wa auto	s an opsy formed?	pric		sy findings available pletion of cause of
		Cor										1 ☐ Yes	201		Yes 2	2□ No
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of	Phys this ral dii	: To	1 Yes 2 Ne		1 □ In 28a. Date of		ER/Outpatien 28b. Time of		8c. Injury	al N				6 Other		
OU	ding h. After fune	tion	1 Natural 5 ☐ Pendi		(Month	Day Year)	Injury	М	8c. Injury Work* 1   Y	? es 2 [				,,		
Division of	Attanding r death. actor: After by the fune	fica	3 ☐ Suicide 6 ☐ Could	not be			ome, farm, str	eet, factory	, office		2				or Rural	Route Number,
á	al or s after al Dira	Certification:	4 Homicide determ		building	g, etc. (Specif	<b>y</b> )					City or To	own, Sta	1(0)		
	To the Hospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After thi completely filled in by the funeral	edicai (				is of examina	wledge, death									
	To the within 2 To tha complet	Me	29b. Signature and title of certific	مر ک				290	. License	number	_		29d. D	ate signed (/	Month, D	Pay, Year)
			50	PE	17	D		l.	00	531	50		FE	B140	os a	006
رار	19		30. Name and address of persor			of death (Iten	n 23a) (Type,	Print)		/1		1	4	5	UII	TEIIO LMBIA
4			5'n ALEUNI	41	CA	CUP	7 A	465	05.	40	TIA	401	400	+()	COL	LNBIA
	Sta	4	31. Date filed (Month, Day, Year		32 Re	gistrar's Signa	ature	ide a								3645
	Registr	ar	FEB 15	CUUD	STATE OF	Wed As	The state of the s	The same of the sa								

1 - State Registrar				Certificate of		Mental Hy	Reg. No.	06 043//
1. Decedent's Na Physician	me (First, Middle, Last)	M 7 1				2. Date of De Month	Day	3. Time of Death
/Medical	Carl (If not institution, give s	M. Zacha		4b. City, Town, o	r Location of De		ary 11,	2006 7:25am M.
LAMITHE	r Baltimore			Towson		411		imore
Funeral 5. Social Security	Number 6. Sex	7. Ag	e (In yrs. last birt	hday) If Under 1 Year	If Under 24 H		rth	Birthplace (State or Foreign Country)
Director 216-30-	1059	IM 2□F	69	rs. Months Days	Hours M	in. (Month, D. July 2	27, 1936	Maryland
Usual Residence	of Decedent		10c. City, Town	or Location				10d. Inside City Limits
Maryla More		imore	l con only, round	Tow	con			1 Tyes 2 No
Md .  10a. State  Md .  10e. Street and I		THOTE	1	10f. Zip Code	3011		10g. Citizen of	What Country?
	ighland Ave	nue			21204			USA
the State of the S		12. Was Decedent Armed Forces?		13. Was Decedent of H		(Specify Yes or N		ce - American Indian, ack, White, etc.
D after a star 1 □ Never M	arried 2XXMarried	1 Yes 2 X		1 ☐ Yes 2 X No	Specify:	orto i noarr, oto.,	Specia	6
5-0036 3 hours atl	I 4 □ Divorced	Year or Dates:	1					White
- 10 % e	15. Decedent's Educecify only highest grade		16a.	Decedent's Usual Occup (Give kind of work done life. DO NOT use retired	pation during most of v dl	vorking	16b. Kind of b	Business/Industry
within 72 (Si	condary (0-12)	College (1-4or :		Office Mana	•		Travel	& Finance Service
To BEE 17. Father's Nam	e (First, Middle, Last)			011100 114114		lame (First, Middle		
Vlan Mental Mental Mental To B	Alvin Z	achary			L	ouise Gu	ıeydan	
19a. Informant's	Name/Relationship (Ty			Mailing Address (Street				
Wynette	Zachary/Wif	е	Avenue	Towson,				
Baltimore  Baltimore  Baltimore  Baltimore  Baltimore  Baltimore  Baltimore  Baltimore  Baltimore  Carlon and Pales  Car	isposition 2  ☐Cremation 3  ☐R	emoval from State	Date		- City or Town, State			
4 Donatio	n 5 ☐ Other (Specify)		/14/06		re, Maryland			
Baltimore, Maryland 2121 Baltimore, Maryland 2121 Departing of the last and 2 should be filled within population of the last and and 2 should be filled within monotrant: If the marked of the last and monotrant: If the mary is marked of the last and in th	Funeral Service License	/ Peres	1	22. Name and Addre		Ruck Tows Towson, N		ral Home, Inc. 1 21204
23a. Part1. Ente shock, or h	er the disease, or compli eart failure. List only or	cations that cause ne cause on each li	d the death. Do nine.	ot enter the mode of dyir	ng, such as card	iac or respiratory a	arrest,	Approximate Interval Between Onset and Death
Physician Immediate Caus disease or conditions of the conditions o	ition	· le	ina	Cancer	_			4 horiths
/Medical resulting in deal		Due to (or as	a consequence o	of):				
Sequentially list	conditions,	Dire to (or as	a consequence o	if)-				
tary, leading to cause. Enter Ut cause. Chise ase that initiated ever resulting in deat	iderlying or injury							
cate be executed physician and transit transit and care be executed to the burial-transit and care that initiates executed care (Care Care Care Care Care Care Care Care	n) Last	Due to (or as	a consequence o	of);				
18760, cate be exprised and physician a the burial calcal Excellent Expression and calcal Expression and calcal Expression and calcal Expression and calcal Expression and calcal Expression and calcal Expression and calcal Expression and calcal Expression and calcal Expression and calculate and c		l						
Med as at tiffice								
BOX (Base a substitution of the past of th	ent pregnant 12 months?		2 Fetal death	3 Ectopic pregnance	y			ate of delivery onth Day Year
O a fight of the second of th	2 □ No	4□Pregnant a 9□ Unknown	t time of death	5 ☐ Other (specify) _				
A Part II. Other signal A Part II.	nificant conditions cor	ntnbuting to death b	out not resulting in	the underlying cause giv	ven in Part I.	23e. Did	tobaccourse cor	ntribute to the cause of death?
transition of the part of the	mphysem	a/				1 🗷	Yes 2 □ No	3 Probably 4 Unknown
cord  Inwrequir  S been s  S should  S should	0 0					24a. Wa	san 24b	Were autopsy findings available
Il Record The law requir cate has been s page 2 should Completed						auto perf 1 ☐ Yes	ormed?	Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☑ 170
Y Yesician: The Yesician of Confidence of Co	ferred to medical				26. Place of E	Death (Check only		
V do not not not not not not not not not no	<b>≥</b> 140	<del></del>	ent 2□ER/Ou	patient 3 DOA		Home 5□Res		
O UC H The Land of D 27. Manner of D 1 27. Manner of D 1 27. Matural	5 Pending	28a. Date of Inju (Month, Da	ury 28b. T ay Year) I	njury Wo	ry at rk?	28d. Describe	how injury occu	rred
Signal Suicide	6 Could not be	ODs. Dissa of in	iver At home for		Yes 2 No	28f Location	/Street and Num	ber or Rural Route Number,
Division of Vital Records,  Is after death.  Is after dea	le determine	building, e	tc. (Specify)	rm, street, factory, office		City or To	wn, State)	ber of Abrai House Number,
es succession of the successio	1 Certifying Phys	sician: To the best	of my knowledge	, death occurred at the ti	me, date and pla	ace, and due to the	e cause(s) and m	nanner as stated.
Division  To the Hoepital or Attendin  Within 24 house after death.  To the Hoepital or Attendin  Within 24 house after death.  To the Funetal Director: All Homicic  San Certificat (Check only only by the further form of the further form)  San Certification  To by the further form of t	<u></u>	ner: On the basis of and manner st	of examination and tated.	d/or investigátion, in my o	opinion, death or	ccurred at the time	, date and place	, and due to the cause(s)
29b. Signatura	nd tille of certifier	(1)	1	29c. Licens	se number		29d. Date sign	ed (Month, Day, Year)
1 / 1	Thuse	fasi	enlu	DZ DZ	4121		2-/13	106
BRU		MBERÜ	death (Item 23a)	Type, Print) 21 WEST	20	TOWSON	/ ND	21204
State 31. Date filed (A	FEB 1 5 200		rar's Signature	Sporte			/	,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 06 MTLDRED /Medical VIRGINIA ANDERS 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FREDERICK ST. CATHERINE'S NURSING CENTER EMMITSBURG
If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🕅 F Yrs. 89 Director 216-05-2016 APR.15,1916 TANEYTOWN, MD. Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28e-f show the Madical Examiner must be notified at 1 ☐ Yes 2 No Director MD CARROLL TANEYTOWN 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 238 U.S.A. 311 ROBERTS 21787 MILL RD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or Items Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "netural", or Item any Injury or other traumation. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE 2 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SEAMSTRESS SEWING 12 17. Father's Name (First Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 WILBERT ALBERT BAKER MARY MARGARET CURFMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1807 WILLOW CREEK COURT, FREDERICK, MD. 21702 ELAINE HOOVER/DAUGHTER 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 D Burial 2 Cremation 3 Removal from State \* 4 ☐ Donetion 5 ☐ Other (Specify) GRACE U.C.C. CEMETERY 2/10/06 TANEYTOWN, MD. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility nce. SKILES FUNERAL HOME tales 136 E. BALTIMORE ST., TANEYTOWN, MD. 21787 23a. Parh. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imm hate Cause (Final disagree or condition resulting in death) STAGE NORMAL PRESSARE s a consequence of): HYDROCEPITALUS Pnysician END 4 cak /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-transit and Due to (or as a consequence of) Box 68760. physician Physiclan/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day 4□Pregnant at time of death 5 Other (specify) P.0. the detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2X No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 XNursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 2 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After or Attending 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funerel Director: A 2 Accident investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide filled in the Hospitel 29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number HO044037 FEBRUARY 9, 2006 rompel-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KREMPEL-Emmitsburg, MD 2172 DONITA J. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

FEB 1

5 2006

DHMH 17 Rev 1/2001

**ORIGINAL** 

			1 - For State Registrar	State of M	aryland / Depa <i>Cei</i>	artment of H <i>tificate of L</i>			ene g. No. 0 0 6	04379
			1. Decedent's Name (First, Middle, Last)					2. Date of Death Month		3. Time of Death
	Physicia /Medic		Susan Lynn Ardin	ger				January		
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County of [	Death
			13044 Gordon Ci			Ha	gerstown		Washing	gton County
	Funeral		5. Social Security Number 6. Sec	7. Ag	ne (In yrs. last birthday) 59 Yrs.	If Under 1 Year Months Days	Tf Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		Birthplace (State or Foreign Country)
	Director		184-36-6962		59 Yrs.			october	21 1946	Pennsylvania
	and **		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	danyl f sho	ō	Maryland Washin	aton	На	gerstown				1 ☐ Yes 2 <b>X</b> No
	the 28s-	rec	10e. Street and Number	5		10f. Zip Code		10	g. Citizen of Wha	it Country?
	3a or	Funeral Director	13044 Gordon Cir	cle		21	742		United	States
	ms 2	era	11. Marital Status	12. Was Decedent	Ever in U.S. 13.	Was Decedent of Hi f Yes, specify Cuba		ecify Yes or No-	14. Race - /	American Indian, White, etc.
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  dig other than "natural", or Itams 23s or 28s-f show event, the Modical Eventian must be notified at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 Yes 25  If Yes, Give Year or Dates:	61-	1 Tes, specily cuba 1 □ Yes 2 ☑ No	Specify:	nican, etc.)	Specify:	White
Ö	2 hor	Completed	15. Decedent's Edu		16a. Dece	ient's Usual Occupa	ation	ing 1	6b. Kind of Busin	ess/Industry
215	hin 7	ple	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or	life.	DO NOT use retired	)	,,,,		
21	e filed within al Hygiene. i other than vent, I.e Mu	200		2		Homemak				l Residence
pu	be filed Ital Hygid of other event, I	Be (	17. Father's Name (First, Middle, Last)					e (First, Middle, M	laiden Sumame)	
<u> a</u>		2	Mark Yeager				Thelma	Barbour		
ar	and sum		19a. Informant's Name/Relationship (Ty			g Address (Street a				
	1 and 2 Health Iem 27 i		Don Price Ardinge	r (husban	20b. Place of Dispo	Gordon C sition (Name of	ircle Hac	erstown	Maryland	1 21742
Ore	e = 5		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ P	temoval from State	cemetery, crer	natory or other plac	θ)			
Ē	tmen tant:		* 4 □Donation 5 □ Other (Specify)		Rest Have		a of Continu			own Maryland
Baltimore,	permit. Pages Department of Important: If it any injury or o		2) sign there of Funeral Service Licens	Fine	1:	Name and Address 331 Easte	יסט בrn Blvd	N. Hager	stown Ma	neral Home aryland 21742
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that cause	d the death. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Gli	oblasto	ma	Hu Hi	forme	2	Onset and Death Month's
	/Medical		resulting in death)	Due to (or as	a consequence of):					
	Examiner		Sequentially list conditions,	D						
	p tis	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):					
	ecute and -trans	каш	that initiated events resulting in death) Last	Due to (or as	a consequence of):					
60,	be ex	E		540 (0/ 40	2 00.100420.100 0.7.					
8760,	icate be executed physicien and s the burial-transit	dical		1						
9 X	eath certific attending p	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy				23d. Date of	f delivery
Вох	atten for u	clan	in the past 12 months?	1☐Live birth 4☐Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			Month	Day Year
o.	that the de ted by the a detached f	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown						
<u>α</u>	The law requires that the death certificate be executed tite has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	by Pt	Part II. Other significant conditions con	ntributing to death b	out not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	acco use contribu	te to the cause of death?
Records,	quires in sign							1 🗌 Ye	s 2 No 3[	Probably 4 Unknown
00	sw require s been si	Completed						24a. Was an autopsy		re autopsy findings available r to completion of cause of
Re	The lav	III O						perform	ed) dear	th? Yes 2 No
Vital		0	25. Was case referred to medical				26. Place of Deat	h (Check only one	)	
<b>/</b>	dis is	To B	examiner? 1 ☐ Yes ≥ No	lospital: 1 🗌 Inpati	ent 2 EP/Outpatier		4   Nursing Ho	me Resider	nce 6 Other (	Specify)
n of			27. Manner of Death 1 XNatural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o	Work		28d. Describe how	w injury occurred	
<u>Ö</u>	Attending at death. ector: After by the fune	catic	2 Accident investigation				Yes 2 No			0 10 11
Division	i Sitte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of In building, e	jury - At home, farm, str tc. <i>(Specify)</i>	eet, factory, office		City or Town,		or Rural Route Number,
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best ner: On the basis of and manner st	of my knowledge, deat of examination and/or in ated.	n occurred at the time vestigation, in my of	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and manne te and place, and	er as stated. due to the cause(s)
	o the	Med	29b. Signature and the of certifier	1	,	29c. License	e number	29	d. Date signed (A	Nonth, Day, Year)
	⊢ s ⊢ ŏ		Hora- CV	lean -	-6 Ph.D.	UD DO	217591		Jan :	312006
			30. Name and address of person who d	ompleted cause of	teath (Item 23a) (Type,	Print)	- 11- 11			1
341	-10		George C. Ne	work	PHD MD	11110 Me	dical (	ampusk	d, Hoke	istory, Mel
	Sta	ite ar	31. Date filed (Month, Pay Year)	06 32. Fregist	rar's Signature	artes			7 3	21742

	ham Bali	1	Amend item#28a,p	enÆ G852, 2/15/06 State of Marylan	d / Depa	<b>delible in</b> adment of	K. Ensure Health an	e All Co <sub>l</sub> Id Menta	<b>pies A</b> l I Hygie	re Legi	ble.	01/	200
		•	1 - For 2-6-06 State 2-6-06 Registrar Amend #'s 28-3	& f.PerMEO PGC C	Cei	rtificate o		u monta	Reg	401	Jb	U4.	380
Ö	Physicia	20	1. Decedent's Name (First, Middle, Last	)		-		2. Date Mor	of Death	Day	Year	3. Time o	of Death
	/Medic		Abraham Isaiah	Ball				Jar	nuary	23 20	06	6:42	Рм
2	Examin	er	4a. Fecility Name (If not institution, give				or Location of D	Death		4c. County		George	a La
	Funeral		Prince George's Ho 5. Social Security Number 6. Sec		last birthday)	Cheves If Under 1 Year	If Under 24		of Birth		9. Birth	place (State	
	Director		214 <b>-</b> 02 <b>-</b> 1580	<sup>1M 2□F</sup> 23	Yrs.	Months Day	s Hours I	Min. 10-	03–19	82	Cou	verly,	
	and w		Usual Residence of Decedent  10a. State 10b. County	10c Cit	, Town or Lo	cation						10d. Inside C	Titu Limito
	Maryli 1 eho	ō	Maryland Prince Ge			linton							2 No
	r 28e	Director	10e. Street and Number			10f. Zip Code			10g	. Citizen of V	Vhat Cou	intry?	
	th wit	ai D	9615 Small Drive			20	735			U.S.A.	)		
	ar dea	nuei		12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of If Yes, specify Cu	f Hispanic Origin uban, Mexican, P	? (Specify Yes	or No-		e - Ameri k, White,	ican Indian, , etc.	
36	irs aft	by Funerai	1 Mever Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 📉 No If Yes, Give Year or Dates:		1⊡Yes 2XIN	o Specify:			Specify	Bla	ıck	
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "natural", or iteme 23e or 28e-f ehow the Medical Examinat must be rediffed at	ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual Occ	upation	faddia a	16	b. Kind of Bu	ısiness/în	ndustry	
7	ithin 7	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			ne during most of red)	working	A	utomot	ive		
7	iled w dygier ther th		17. Father's Name (First, Middle, Last)	2	Deta	iler	19 Mothor's	Name (First, I	Middle Me	idon Sumom			
and	d be f ental h ced of	To Be	Keith Edward Ba	11			Sylvi		Weld		9)		
ary	shou ind M mar	-	19a. Informant's Name/Relationship (Ty		19b. Mailir	ng Address (Stre	et and Number of				State, Zij	p Code)	
Ž	and 2 selth a n 27 l		Sylvia A. Brown	/ 0 0	Wald	orf, Mai	ryland,	ce 20603					
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelth and Mental Hygiene. Important: If item 27 ie marked other then "natural", or iteme 23a or 28e-1 ehow eny injury or other treumatic event, the Medical Examinat must be multipled at once.		20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ F	20b. P	lace of Dispo emetery, crer	sition (Name of natory or other p	lace)	Date	200	c. Location -	City or To	own, State	
≣	t. Pag ntmen ntant:		4 ☐ Donation 5 ☐ Other (Specify)	Lir	coln N	1em. Cem	etery 0	1-31-06	Su	itlan	1, Ma	aryl <u>a</u> n	d
Ba	Depa Impo eny ir		21. Signature of Funeral Service Licens	Bacon CC3			Street,						.с.
			23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that caused the death	Do not ent		. /			1		Approxima Interval Be	tween
	Physician		Immediate Cause (Final disease or condition resulting in death)	Multi	sell	Gu	shot	Wo	und	A		Onset and	Death
	/Medical Examiner		resulting in dealth)	Due to (or as a conseq	ence of):	- / -							
1		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						_		
	te be executed ysicien and le burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
,09	be executed icien and burial-transit		resulting in death) Last	Due to (or as a consequent	uence of):								
	cate b	dicai		d		-							
89 X	ding p	/Me	IF FEMALE:	23c. If yes, outcome of pregna	nev					004 D-4			
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certificate rindeath. If death. ector: Atter this certificate hes been signed by the attending physby the funeral director, pege 2 should be detached for use as the	Physician/Medi	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d	death 3	Ectopic pregnar Other (specify)				Moi	e of deliventh		Year
Ö.	t the c by the tached	hys	9 Unknown	9□ Unknown									
S, F	gned gned be del	by P	Part II. Other significant conditions con	ntributing to death but not res	ulting in the u	nderlying cause	given în Part I.	236	. Did tobac	co use conti	ibute to t	the cause of	death?
ord	requir een si nould	ted						_	1 🗌 Yes	2 No	3 🗌 Prot	bably 4 🗌	Unknown
ğ	e 2 st	Completed						24a	. Was an autopsy	. F	prior to co	opsy findings empletion of a	
a	n: Th licate r, peg								yes 2		leath? Yes	2□ No	
₹	sicia certifirecto	o Be	25. Was case referred to medical examiner?  ↓↓↓ Yes 2 □ No	lospital: 1 ☐ Inpatient 25	ER/Outpatier	- 00 DOA   0	ther	Death (Check		- 0 1704	- 40		
jo l	g Phy er this eral d	n: To	27. Manner of Death	28a. Date of Injury	28b. Time of		<del></del>	ng Home 5 [ 28d. Des		injury occurr		19)	
Ö	endin sath. or: Aft he fun	Certification:	1 Natural 5 Pending investigation	(Month, Day Year)	Injury 17:57	2(PM 1)	Yes 2 No	De	rea	secl	Sh	et	
ΣĬ	or Atte	rtific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specify	me, farm, str		0	281. Loc	ation (Stree	t and Numb state)	er or Rura	al Route Num	nber,
	Hospitel or 24 hours efte Funerel Dir tely filled in I		200 Conffice 1/7 Confidence Physics	Car	on s	treel		54.	Barna	pas 9	TB	edtord	Way
	To the Hospitel or Attending Physicien: The law within 24 hours effer death.  To the Funerel Director: Affer this certificate hes completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exami	sician: To the best of my kno ner: On the basis of examina and manner stated.	wieage, deati tion and/or in	vestigation, in my	time, date and p opinion, death of	place, and due occurred at the	to the caus time, date	e(s) and ma and place, a	nner as s and due t	itated. the cause	s)
	To the within 2	Me	29b. Signature and title of certifier	) A A		29c. Lice	nse number		29d.	Date signed	(Month,	Day, Year)	
	(15)		Susur	John			OCME		·	Januai	cy 24	4, 200	6
			30. Name and address of person who co	ompleted cause of eath (Item	23a) (Type,		· ·	1 D 1	• • •	7.5	7	. 4 010	01
	- JO 6	-	31. Date filed (Month, Day, Year)	7 /1/	turo	111 P	enn Stre	et Bal	rimor	e, Mai	.yıar	10. ZIZ	)T
9	Sta Registr		1011 - 4	32. Registrar's Signa									
DH	IMH 17 Rev 1/20	001	2000	an & f									

Michael J. Barron 06-1005 AKG

			1 - State Registrar	State of Mary		ertificate of Death	ind Mental Hy	rgiene () () 6 Reg. No.	04381
	Physici /Medic		Decedent's Name (First, Middle, Las     MICHAEL	JOSEPH		BARRON	2. Date of Do Month Februa	Day Yea	3. Time of Death 2:25 P M
	Examir		4a. Facility Name (If not institution, give 2632 Harkins Road			4b. City, Town, or Location of Norrisville	f Death	4c. County of De Harfor	eath
	Funeral Director		ETO JO TE TE	MA OCT	yrs. last birthday 54 Yrs.	Months Days Hours	Min. 8. Date of Bi (Month, Di 9/24	rth ay, Year) 9. E 1951	Birthplace (State or Foreign Country) Maryland
	Maryland I-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD. Harf		c. City, Town or I	ocation Pyles	ville		10d. Inside City Limits 1 ☐ Yes 2 🛣No
	ath with the 23a or 28s	ral Direc	10e. Street and Number 2205 Amoss M	ill Road		10f. Zip Code 2113	2	10g. Citizen of What United	Country? States
036	filed within 72 hours after death with the Maryland Hygiene. uther then "naturel", or Iteme 23a or 28a-f ehow ent, the Madical Examinar must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	r in U.S. 13	Was Decedent of Hispanic Orig If Yes, specify Cuban, Mexican, 1 ☐ Yes 2 No Specify:	gin? (Specify Yes or No , Puerto Rican, etc.)	14. Race - Ar Black, Wi Specify:	merican Indian, hite, etc. White
Baltimore, Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then "naturel", or iteme 23s or 28s-f show sumatic event, the Medical Examinar must be notified at	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(Giv	edent's Usual Occupation e kind of work done during most DO NOT use retired)	of working	t6b. Kind of Busines	
and 2	e ta b	Be	12   17. Father's Name (First, Middle, Last) William	McKee			r's Name (First, Middle		seling
Maryl	d 2 should th and Men 7 le marke treumatic	ဥ	19a. Informant's Name/Relationship (7) Johnnie R. Bar	ype, Print)	19b. Mai	rron Mi ling Address (Street and Number 5 Amoss Mill			a, Zip Code)
more,	permit. Pages 1 and 2 should Department of Health and Men Important: if item 27 is marks any injury or other treumatic <u>pnce.</u>		20a. Method of Disposition  1 Burial 2 A Cremation 3 4 Donation 5 Other (Specify	2	Ob. Place of Disp	osition (Name of ematory or other place)  Cremation 2	Date	20c. Location - City	or Town, State
Balti	Departm Departm Importa any inju		21. Signature of Funeral Service/Lidens		11_	22. Name and Address of Facility E.G. Kurtz &	Jarret	tsville,	Maryland
The second	Physician /Medical Examiner		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	a. Due to (or as a co	ons uence of):	nter the mode of dying, such as o	cardiac or respiratory a	arrest,	Approximate Interval Between Onset and Death
68760,	ifficate be executed g physicien and as the burial-transit	edical Examiner	rf any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co					
P.O. Box 6	ires thet the death certif signed by the ettending d be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	□Ectopic pregnancy □ Other (specify)		23d. Date of o Month	delivery Day Year
rds, P	w requires thet been signed b should be deta	ed by PI	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the	underlying cause given in Part I.			to the cause of death?  Probably 4 □Unknown
al Reco	vicien: The law re certificete hes bev rector, page 2 sho	Completed					24a. Was auto perf 1/A-Yes	opsy prior t ormed? death	autopsy findings available o completion of cause of es 2□ No
Division of Vital Records,	To the Hoepital or Attending Phyelcien: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the ettendin completely filled in by the funeral director, page 2 should be detached for use	Certification; To Be	25. Was case referred to medical examiner?  1 X Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	28a. Date of Injury (Month, Day Ye.	2:10	ont 3 DOA Other: 4 Nur of 28c. Injury at Work? PM 1 Yes 2 DA	28d. Describe	how injury occurred  water water	chelecollsia.  Bural Route Number.
Ω	To the Hospital or within 24 hours aff To the Funeral Di completely filled in	Medical Cer	29a. Certifier (Check crity one)  1 Certifying Phy 2 Medical Exam	sician: To the best of my iner: On the basis of exa	road y knowledge, dea	ith occurred at the time, date and	place, and due to the	own, State)  Right Down:  cause(s) and manner, date and place, and d	as stated.
)	To the vithin 2 To the comple	Mec	29b. Signature and title of certifier  January	and manner stated.		29c. License number O.C.M.E.		29d. Date signed (Mo	onth, Day, Year)
	Sta	te	30. Name and address of Arson who co Tasha Zavce nberg 31. Date filed (Month, Day, Year)	2 M.D. 32. Registrar's		111 Penn Stre	eet, Baltin	more, Maryl	and 21201
	Registr		FEB 1 5 2008	Sie con 1	No. Inches				

CPM 06-00589

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Ronald Burphy State of Maryland / Department of Health and Mental Hygiene Certificate of Death UNK Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician ROLAND BURPHY ٠TR. 23, 2006 January 16:14 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5335 85th Avenue #103 Prince George's New Carrollton 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) 1**⊋**M 2□ F 22 577-21**-**6647 Yrs. Director APRIL 16,1983 MONROVIA LI Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location ehow. 10d. Inside City Limits rai', or itema 23a or 28a-f ehor Examiner must be notified at PRINCE GEORGE'S 1 XYes 2 No MD NEW CARROLLTON Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20785 5335 85th AVE., #103 LIBERIA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give realth and Mental Hygiene.

"m 27 ie marked other then "--er traumatic eve---- Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2yrs SALES PERSON RETAIL 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Peges 1 and 2 should be in ment of Health end Mental I ဂ ROLAND BURPHY SR. NANCY NAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i NANCY BURPHY/MOTHER 9957 GOOD LUCK RD. #201 LANHAM, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Depertment of Importent: If eny Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 2-4-06 BRENTWOOD, MD LINCOLN CEM. Funeral Service Litensee 21. Signatur 22. Name and Address of Facility CAPITOL MORTUARY 1425 MARYLAND AVE., N.E. WDC 20002 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Gunshut wounds disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immisdiate cause. Enter Underlying Cause (Disease or injury that initiated events Due to for as a consequence of Examine physicien and s the burial-transit The law requires thet the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 Completed by Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day 4□Pregnant at time of death signed by the a 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 Yes 2 □ No 24a. Was an page 2 s autopsy performed? of Vital 2 ☐ No or Attending Physicien: : After this certifications a funeral director. 25. Was case referred to medical examiner?
XX Yes 2 \sum No 26. Place of Death | Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence MAOther (Specify) SCENE 28d. Describe how injury occurred Subject WKS Certification: 27. Manner of Death 28b. Time of 28c. Injury at Work? Division Injury 1 Natural 5 Pending rector: SMOT 4:11 PM 2 Accident investigation 1 ☐ Yes 2 🕱 No 1123/06 the 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28l. Location (Street and Number or Rural Route Number, City or Town, State) 5335 857h NC, 403 filled in by To the Hospital or within 24 hours eff To the Funeral DI completely filled in apartment building New Carrailton, md. 1 Certifying Physician: To the best of my knowledge, death coursed at the time, date and place, and due to the cause(s) and manner as stated.

ZX Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 24, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pameki E. Southall, MD 111 Penn Street, Baltimore, Maryland 21201 31. Date filed (Month, Day, Year)

State Registrar

JAN 3 1 2006



			1 = For State Registrar	State of Marylan		artment rtificate			d Mer		ene	006	04384
			1. Decedent's Name (First, Middle, Last	)					2.	Date of Death	1		3. Time of Death
	Physici /Medio		Kenneth Edward H	Burdette					J	Month anuary	30	2006	6:22 P M
)	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or Location of Death					4c. Co	unty of Dea	th
			Frederick Memori	ial Hospital		Fr	eder:	ick			Fr	ederi	ck
	Funeral		Social Security Number     6. Se		ast birthday)	If Under 1	1 Year Days	If Under 24 Hours		Date of Birth (Month, Day,	Year)	9. Bir	thplace (State or Foreign ountry)
	Director	]		M 2□F 82	Yrs.		July	110013		ri1 29			aryland_
	pu *		Usuel Residence of Decedent  10a. State 10b. County	10c Cib	, Town or Lo	reation							10d. Inside City Limits
	sho sho	۱	,										1
	Ne M	ecto	Maryland Frederic	CK M	onrovi								1 Tyes 2 No
	di di	급	10e. Street and Number			10f. Zip (				10	g. Citize	n of What C	ountry?
	s 23	rai	12103 Tracy Cour				21770	<u> </u>			U.S		
	er de item	by Funeral Director	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decede f Yes, speci	ent of Hisp ify Cuban,	panic Origin' Mexican, P	? (Specify uerto Rica	Yes or No- an, etc.)	14.	Black, Whi	erican Indian, te, etc.
36	rs aff	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1√7Yes 2 No IFYes, Give Year or Dates: WWII		1 ☐ Yes 2	X No	Specify:			S	oecity: T.	<i>T</i> hite
21215-0036	within 72 hours after death with the Maryland ene. then 'naturel', or items 23e or 28e-f show ha Madical Examinar must be notified at	edit	15. Decedent's Edu		16a Decer	dent's Usual	Occupati	ion		- 1	Sh Kind	of Business	
15	in 72 an 'n	Completed	(Specify only highest grad	le completed)	(Give	kind of work	k done du e retired)	ring most of	working			Estat	
12	the interest	E o	Elementary/Secondary (0-12)	College (1-4or 5+)	Own	er/Op	erato	or			Insu	rance	Agency
	Hygie other	Bec	17. Father's Name (First, Middle, Last)						Name (F	irst, Middle, M			
Maryland	2 should be filed withir and Mental Hygiene. Is marked other then eumatic event, the Me	To B	Hubert Perry	Burdette				Lou	ise	Harn	ьd		
μŽ	shound M	-	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address	(Street an			oute Number,		own, State,	Zip Code)
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23e or 28e 1 show or other freumatic event, the Madical Examinar must be notified at		Lynn Burdette - W	life						ovia,			21770
ē,	s 1 a if Hei item othe	Ì	20a. Method of Disposition	-	lace of Dispo	sition (Name	e of		Date				Town, State
Ë	Pages nent of I int: If it		1 Burial 2 Cremation 3 ☐F 4 ☐ Donation 5 ☐ Other (Specify)	nemoval from State	e Grov				3/06	M	ount	Airv.	Maryland
Baltimore,	그 돈 돈 중 .		21. Signature of Funeral Service Licens										•
ä	Dapa Impo eny ir		Novert d.	Villiams	Mo	Leswo:	rth-V	Villia	ms P	.A., F	unera	al Hou	ne 1 20872
			23a. Part1. Enter the disease, or comp	lications that caused the death	n. Do not ent	er the mode	of dying,	such as car	rdiac or re	mascus spiratory arre	st,	Lylanc	Approximate
	Physician		shock, or heart failure. List only o		/	0	,		/	Ο.			Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Athero SC. Due to (or as a consequence)	leace of)	- ( -	1141	6 JASC6	4/12	1315	e150		76 years
	Examiner												
	الرجعة	Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ	uence of):								
	outed nd ransil	Examiner	that initiated events	c									
ó	execut en end rial-trar	EX	resulting in death) Last	Due to (or as a consequ	uence of):						-		
8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien end page 2 should be detached for use as the burial-transit	dical	(	d									
9	ng pt	4	IF FEMALE:										
Вох	eath certific attending p	an/l	23b. Was decedent pregnant	23c. If yes, outcome of pregna 1 Live birth 2 Fetal		Ectopic pre	onancy				230	d. Date of de	
	e dea	Sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of de 9☐ Unknown		Other (spe						Month	Day Year
P.O.	d by t	Physician/M	9 Unknown						Т				
	uires thet the der signed by the a ld be detached f	Ď	Part II. Other significant conditions co		Ilting in the u	nderlying ca	iuse given	in Part I.					o the cause of death?
Records,	v requir been si should	ted	I ROSTATE	LANCER					_ [	1 🗆 Ye:	s 2 🗆 l	No 3□P	robably 4 🛎 Unknown
ec	as be	pie								24a. Was an autopsy	. 2	24b. Were a	utopsy findings available completion of cause of
<u> </u>		Completed								perform	ed?	death? 1 ☐ Yes	
of Vital	Physicien: this certificatal director, I	Be (	25. Was case referred to medical examiner?					26. Place of	Death (C	heck only one			
7	hysi his o	ဥ	1 ☐ Yes 2 ☐ MO		ER/Outpatien	t 3 DO	Other:	4 🗆 Nursin	ng Home	5 🗆 Resider	nce 6	Other (Spe	ecify)
_		on:	27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28	c. Injury a Work?	ıt	28d	. Describe how	w injury o	ccurred	
Sio	eath. or: A	cati	2 Accident investigation			М	1 □ Ye	s 2 No					
Division	irsct n by	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory,	office		28f.	Location (Str. City or Town,	eet and N State)	lumber or R	ural Route Number,
	urs al												
	Hosp 4 hou Fune	cal	(Check only 2 Medical Exami	sician: To the best of my kno- ner: On the basis of examinal	wledge, death	occurred a vestigation, i	it the time	, date and p	lace, and	due to the car	use(s) an	d manner a	s stated. e to the cause(s)
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai	one) 29b. Signature and title of certifier	and manner stated.									
	5 × 5 0		250. Signature and title of certifier			_	License r		7	29			th, Day, Year)
_	AI		1/17/	My			100	3515			1.	3100	>
H	10,		30. Name and address of person who of		23а) (Туре,	Print)	. (	_	The	imest,	M	0 0	.700
12.	C - C		31. Date filed (Month, Day, Year)	32. Redistrar's Signal		CENE			1-14	/	121	0 2	1/10
3.	Sta Registr		FEB 0 2 2		H A	barte	,						

State of Maryland / Department of Health and Mental Hygiene Reg. No.U U 6 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** : 36 AM CATHERINE D. CASTELLANO 0 26 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Mari Gomese WASHINGON ANGUART HOSD THAT Many If Under 1 Year If Under 24 H Months Days Hours M 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 XF Director 578-14-9234 90 Yrs. SOUTH CAROLINA Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits rel', or items 23a or 28a-f show Exemiser must be notified at 1 X Yes 2 □ No Director MD PRINCE GEORGE HYATTSV1LLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6500 RIGGS ROAD 20783 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced BLACK "neturel" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry othar than Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SECRETARY 12TH GRADE U. S. POST OFFICE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Itam 27 Is markad oth eny injury or other traumattc evant ones. Be FDWARD KITT1E M1TCHELL DANIEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GLORIA T. YOUNG--NIECE 3371 DENVER ST., S. E. WASH., DC 20020 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2-1-06 ARLINGTON NAT. CEM. 4 ☐ Donation 5 ☐ Other (Specify) ARLINGTON. VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the of the Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin y Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Ener Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burial-transil that initiated events attending physician and resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mon Month Dav 5 Other (specify) 4 Pregnant at time of death signed by the a Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Miknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 2 □ No 2 🔽 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient Certification: To 2 ☐ A/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Mann Death 28d. Describe how injury occurred 28b Time of 28c. Injury at Work? 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the Diractor: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 within 24 hours To the Funeral 29a. Certifie 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 01-26-2006 of person who completed cause of death (Item 23a) (Type, Print) 7600 MAGKOD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 0 2006 Registrar

		•	For State Registrar	State o	f Marylar	•	irtment of H tificate of i		-	giene Reg. No.	) 6	04386
1	*		1. Decedent's Name (First, Middle,	Last)					2. Date of De	Dav	Year	3. Time of Death
B	Physici /Medic		Warren Call	ahan					JANUI	KY 27,	2006	10:00 AM
	Examin	- 4	4a. Facility Name (If not institution,	give street and nu	mber)		4b. City, Town, or	r Location of Dea	ith	4c. Cour	ity of Death	
		Ş.,	Doctor's Comm	unity Hos	spital		L	anham		Pr	ince	George's
E.	Funeral		5. Social Security Number 6	. Sex	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th	9. Birth	place (State or Foreign
JÆ5	Director		250-26-2134	1 <b>X</b> M 2□ F	8	4 Yrs.						h Carolina
	pud &		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ty, Town or Lo	cation					10d. Inside City Limits
	sho sho	5	,			.,,						1 X Yes 2 □ No
	Ne N	Director	Maryland Princ  10e. Street and Number	e George	s		· · · · · · · · · · · · · · · · · · ·	Glenn Da	ale	10 02	(147) 10	
	with t	ក់					10f. Zip Code	20760		10g. Citizen o		•
	72 hours after death with the Maryland natural', or Iteme 23e or 28e-f show Iteal Examiner must be notified at	Funeral	6313 Wood Po		VE edent Ever in U	10 12 1	Man Danadant of H	20769	Coopfy Von as No		ited ace - Amen	States
	ltem Der de	'n	11. Marital Status  1 □ Nøver Married 2 ☒ Marrie	Armed Fo	orces?	13. 1	Vas Decedent of H Yes, specify Cuba	an, Mexican, Pue	into Rican, etc.)	B	lack, White	etc.
36	rs aff	by F	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Gi	ve T		☐ Yes 2🏋 No	Specify:		Spec	ifv:	rican erican
21215-0036	hou	ed	15. Decedent's			16a, Dece	lent's Usual Occup	ation		16b. Kind of		
15	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work done	during most of w	orking			, addity
77	filed within Hygiene. Ither then ent, the We	E O	Elementary/Secondary (0-12) 8th	College (	1-40r5+)		Cab D	river		Se1	f-Emp	1oved
	Hyg othe	BeC	17. Father's Name (First, Middle, La	ast)					ame (First, Middle			
Maryland	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other then 'natural', or Iteme 23s or 28s-f show aumatic event, the Medical Examiner must be notified at	To B	Fred Ca	11ahan					Reath	na Edmo	nd	
3	shou nd M mar	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	g Address (Street	and Number or F	Rural Route Numb	er, City or Tow	m, State, Zi	p Code)
Š	nd 2 alith a 27 le		Leana Callaha	n/Wife		6313	Wood Po	inte Dr	., Glenn	Dale,	MD 2	0769
<u>6</u>	t Heer t Heer tem othe	1	20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place	ral	Date	20c. Locatio	n - City or T	own, State
گل 1	eges ent o nt: If y or		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		State	-	femorial		3/2006	Lan	dover	. MD
altimore,	artm ortar Injur		21. Signature of Auneral Service Li		l IId	-	. Name and Addre		Stewart			
ä	permit. Peges 1 and 2 should be Department of Heelth and Menta Important: If Item 27 Ie marked eny Injury or other traumatic es once.		) latin T	Tevant	TIT		4001 B	enning 1	Rd., N.E.			
ú			23a. Part1./Enter the disease, or c	omplications that	caused the dea	th. Do not ent						Approximate
			shock of heart failure. List o	nly one cause on	each line.							Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. 7100	(or as a consec		yer 1	1940 CONC	7			
	Examiner	-		Due to	(or as a consec	quence oi):						
\$4. '	-\$	er	Sequentially list conditions, in any, leading to immediate	b. Due to	(or as a consec	quence of).						8-2-41
	uted s	두	cause. Enter Underlying Cause (Disease or injury									
	al-tre	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a consec	quence of):					_	=======================================
58760,	icate be executed physicien and s the burial-trensit	dical		4								
9		-		0.		·						
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m	death s ette d for	2	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Preg	birth 2 ☐ Fet nant at time of o		]Ectopic pregnancy ] Other (specify)	/			Month	Day Year
Р. О.	the c	Physician/M	9 Unknown	9□ Unkr	own							
	res that the de signed by the e i be deteched f	by P	Part If. Other significant condition	s contributing to o	leath but not re	sulting in the u	nderlying cause giv	en in Part I.	23e. Did 1	obacco use co	ntribute to	the cause of death?
<u>p</u>	quire n sig	d b	Diabete, H	iperten	sign, (	Cansed	VR HANA	Fail	re 10	Yes 2□No	3 Pro	bably 4 Unknown
00	w require s been si should I	Completed	,	1	,	δ			24a. Was	an 24	b. Were aut	opsy findings available
Re	The law	mc								psy omed?	prior to co death?	ompletion of cause of
Ø	ilcian: Th certificate rector, pag	ပိ	25. Was case referred to medical					26 Place of D	1 ☐ Yes eath (Check only	260 No	1 🗌 Yes	2 No
5	slcia s cert irect	o B	examiner?	Hospital:	Inpatient 2	ERVOutpatier	t 3 DOA Oth	200	Home 5 ☐ Resi		Whos (Cons	4.1
Division of Vital Records,	Attending Physician: The law requires that the death certifundeath. It death. Cotor: After this certificate hes been signed by the ettending by the funeral director, page 2 should be deteched for use a	-	27. Magner of Death	28a. Date	of Injury	28b. Time o			28d. Describe			ny)
on	th. : After s funer	ᅙ	1 Natural 5 Pending 2 Accident Investiga	1	nth, Day Year)	Injury		nk? Yes 2 □ No				
/ISI	or Attendated after death Director:	flea	3 ☐ Suicide 6 ☐ Could no	ot be 28e. Pfac	e of Injury : At h	nome, farm, sti	eet, factory, office				m <i>ber</i> or Rui	ral Route Number,
ă	2 4 2 5	Certification:	4 Homicide	build	ling, etc. (Spec	iry)			City or To	wn, State)		
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier & Certifying	Physician: To th	e best of my kn	owledge, deat	occurred at the til	me, date and pla	ce, and due to the	cause(s) and	manner as	stated.
	n 24 n 24 ne Fu	edical	(Check only 2 Medical E	xaminar: On the t	pasis of examin oner stated.	ation and/or in	vestigation, in my o	pinion, death oc	curred at the time,	date and plac	e, and due	to the cause(s)
	To th withir To th	M	29b. Signature and title of certifier	10			29c. Licens			29d. Date sig		*
			Man X	of bus	MI		1188	6/131	7	TANUA	cy 2	7 2006
)	(3)		30. Name and address of person w	no completed cal	se of death (Ite	m 23a) (Type,	Print)				1 0	
	(0)		HEATHER N	DAVIS M.	5. 5	75 M	AIN STR	EET 5	VITE 35	1 6	9 UR E	7 2006 4, MD 30707
	Sta		31. Date filed (Month, Day, Year)	inc &	Registrar's Sign	ature	A.					
1	Regist	ar	FEB 0 1 20	סטו	M M	17/10						

and the same		1 - For Amend item RegistrarAmend # 20b.&C. 1. Decedent's Name (First, Middle, Last,							2. Date of De	ath	3. Time of Death	
Physici /Medic		Will Colem	nan						Month Januar	v 29 20	Year 06 01:45	
Examin		4a. Facility Name (If not institution, give	street and nun	nber)	4	4b. City, Town,	or Location	of Death		4c. County	of Death	
		Washington Adv				Ta	koma	Park			tgomery	
Funeral Director		5. Social Security Number 6. Se. 226–44–4170	X ∑M 2□F	7. Age (In yrs. last b.		Months Days		Min.	8. Date of Bir (Month, Da	ay, Year)	Birthplace (State or Fore Country)	
JII ECTOI		Usual Residence of Decedent							reb. 1	8, 1936	Virginia	
Show	L	10a. State 10b. County		10c. City, Tov	wn or Loca	ition					10d. Inside City Lim	
or 28a-f show se notified at	ecto	Maryland Prince G	George's	5			apito	1 Hei	ghts	40.000 //		
a or		10e. Street and Number 4713 Pard Road				10f. Zip Code	207	4.3		10g. Citizen of W		
ms 23	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.S.	13. Wa	as Decedent of (es, specify Cul			ecify Yes or No		ed States - American Indian,	
of Health and Mental Hygiene. Item 27 is marked other then "naturel", or Items 23s or 28s-f show other traumatic event. Its Medical Exerciment must be notified at	by Fur	1 ☐ Never Married 2 ☐ Married 31 ☑ Widowed 4 ☐ Divorced	Armed For 1 ☐ Yes If Yes, Giv Year or Da	2 <b>X</b> No e No		∕es, specify Cul ]Yes 2∏XNo			Rican, etc.)	Specify:	k, White, etc. Black	
a la	ted	15. Decedent's Edu		168		nt's Usual Occu		et at wark	5.7	16b. Kind of Bu	siness/Industry	
. u. u.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1	-4or 5+)	life. DC	NOT use retir	ed)	St OF WORK	119			
ygien ver th	Con	6th			_	La	bor				rivate	
od otl	Be	17. Father's Name (First, Middle, Last)  Howard Co	1				18. Moth	iers Name	•	, Maiden Sumam	θ)	
and Mental Hygiene. is marked other then aumatic event, the Max	ဥ	19a. Informant's Name/Relationship (T)		19	b. Mailing	Address (Stree	at and Numb	er or Rura		Adams er, City or Town,	State, Zip Code)	
uith ar 27 is r trau		Esther Taylor/Fi			_					hts, MD	20743	
ant of Hee at: If Item y or othe		20a. Method of Disposition  1		State 20 Miaca		ion Came of the Centre Ceme te			<sup>2</sup> 2006	<del>Suitland</del>	con DC tate	
Depertment of Health a important: if Item 27 is eny injury or other tra-		21. Signature of Furieral Service Licens		A 111		Name and Addi	ess of Facil	ity St	ewart	Funeral Wash., D	Home	
ysician and free prize and street and the prize-transit and the prize transit and the pr	dicai Examiner	23a. Part1. Enter the disease, or compositions, of heer failure. List only of Immediate Jales (Final disease or condition resulting in death)  Sequentially list conditions, if any, feating to limit ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (	or as a consequence	a of):	tuny	A	5-12			Interval Between Onset and Death	
ittending   or use as	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify) □ 9 □ Unknown									23d. Date Mor	e of delivery hth Day Year	
n signed by the a uld be detached f	b	Part II. Other significant conditions co	ntributing to de	eath but not resulting	in the und	erlying cause g	iven in Part	1.			ibute to the cause of death 3 ☐ Probably 4 ②Unkno	
ate has been si page 2 should I	Completed								24a. Was auto perfe 1 🗀 Yes	psy prmed? d	Vere autopsy findings available to completion of cause leath?  Yes 2 No	
certificate rector, pag	Be (	25. Was case referred to medical examiner?						e of Death	Check only	one		
₩ Đ	6	1 ☑ Yes 2 ☐ No  27. Manner of Death				30 000				dence 6 Othe		
After	lon	1 ☑ Natural 5 ☐ Pending	(Mont	of Injury 28b. th, Day Year)	Time of Injury	28c. Inj	uryat ork? ]Yes 2.[		280. Describe	how injury occurr	ed	
within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	280. Place	of Injury - At home, ing, etc. (Specify)	farm, stree				28f. Location ( City or To	(Street and Number or Rural Route Number, wn, State)		
Funeral Funeral lely filled	edical C	29a. Certifier 1 🗓 Certifyin. (Check only one) 2 🗆 Medi ami	sician: To the iner: On the ba and many	asis of examination a	ya, ucath c ind/or inve	occurred at the stigation, in my	time, data a opinion, de	ath occurr	and due to the ed at the time,	cauce(c) and na date and place, a	and due to the cause(s)	
0 0	Me	29b. Signature and title of certifier					nse number			_	(Month, Day, Year)	
within 2 To the				1-		1//	771	7		1-30	-2006	
within 2 To the		(5/6	1			73	20			1 00	2006	
within 2 To the comple		30. Name and address of person who co	ompleted caus	of death (Item 23a	) (Type, Pr		20			7 00	2006	

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** JAN.  $29^{\text{ay}}$ 2006 CLAGGETT W. CLIPPER 11:56A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Suburban Hospital MONTGOMERY Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 **X**M 2 ☐ F Hours Months Director 214-28-7571 76 Yrs. 10,1929 Maryland Usual Residence of Decedent the Maryland 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Germantown Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Examiner must be 11403 Flowerton Place 20876 U.S.A. death by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Peges 1 and 2 should be filed within 72 hours after of the tof Health and Mental Hygiene. Black, White, etc. 1 ☐ Yes 22020 If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TvNo Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Coltege (1-4or 5+) Attendant Gasoline Station 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rosa Watson Bose Clipper 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20879 19a. Informant's Name/Relationship (Type, Print) f Health item 27 i Edith Stewart (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place) ertment of He ortant: if iter injury or oth 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State
Conation 5 Other (Specify) 2-3-06 Seneca Church Cem Germantown, MD 21. Signatur Janeral Service Licenses 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 246 N. Wash. St., Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHRONIC OBSTRUCTIVE PULMONARY DISEASE **Physician** /Medical Examiner sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) ettending physicien and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 □Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? certificete 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Medical Certification: To 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation i Director; Afr 1 ☐ Yes 2 ☐ No the f 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pmpletely filled in by 4 Homicide ö the Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Con Byen, My 00057124 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13219 Executive Park Ter., Germantown, MD 20874 Truong Bal, M.D. 31. Date filed (Month, Day, Year) 32 Hegistrar's Signature State FEB 0 1 2006 Registrar

			for State	State o	f Marylar	*	artment of H		•		000	01000
			1. Decedent's Name (First, Middle, Las		tificate of	Death	2. Date of De	Reg. No.	UUb	14369		
	Physici	an	36	1.7					Month	Day	Year	3. Time of Death
	/Medio		Mary A.  4a. Facility Name (If not institution, give	street and nu	Carde	ella	4h City Town o	r Location of Dear	Jan.	30,	2006 County of Death	09:09A M
	Examir	er			,	U t			(n		100	
	Funeral		Brighton Gardens a  5. Social Security Number 6. So		nasnip 7. Age (In yrs.		Chevy C		8. Date of Bir		Montgon	nery
	Funeral Director			□M 2 <b>X</b> )F	93	Yrs.	Months Days	Hours Min		y, Year)	C01	wintry) W York
	D		Usual Residence of Decedent					1	верг.	29, 1	912 Ne	WIOTK
	nytan how		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
	e-f s	ţō	Maryland Montgome	ry	Che	evy Cha	ise					1¶Yes 2□No
	th th or 28	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Co	untry?
	23e	la I	5555 Friendship B	lvd.			2081	5			USA	
	er de	Funeral	11. Marital Status	Armed Fo		I.S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puer	Specify Yes or No	- 1	4. Race - Amer Black, White	
36	within 72 hours atter death with the Maryland ene. then "neturel", or items 23e or 28e-f show I's Madical Examirer must be notified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes If Yes, Giv	/8	į	1 ☐ Yes 2 🗓 No	Specify:			Specify:	
2-003	hour ture	a pe	15. Decedent's Ed	Year or D	ates:	160 Dags	tantle Havel Occur				W	hite
5	in 72	Completed	(Specify only highest gra	de completed)		(Give	tent's Usual Occup kind of work done of DO NOT use retired	during most of wa	nrking	16b. Kin	d of Business/I	ndustry
2121	with iene. ther	mo m	Elementary/Secondary (0-12)	College (1	-4or 5+)		Keeper	,		R1111	ding Su	pply Co.
ō	filed Hyg other	Be C	17. Father's Name (First, Middle, Last)			Doore	жеерег	18. Mother's Na	me (First, Middle,			ррту со.
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other then "neturel", or items 23e or 28e-f show may injury or other treumatic event, if a Macical Examination at the page.	To B	Thomas Leo					Ange 1	ina Cast	iolia	one	
ary	shound M	-	19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address (Street					ip Code)
_	alth a 27 is		Thomas A. Cardell	a/Son			River Ro					
altimore,	of Her		20a. Method of Disposition		20b. F		sition (Name of natory or other place		Date 31,		ation - City or T	Fown, State
Ĕ	Page In Inch		1 ☐ Burial 2 🖾 Cremation 3 ☐ `4 ☐ Donation 5 ☐ Other (Specify	Hemoval from	Ciaro		tan Cremat	1 -		Alexa	andria,	Virginia
	rmit. partn porte y inju		21. Signature of Fundal Service Vicer	60 ) //	7	22	. Name and Addre					U
<u>m</u>	8 9 E 9	0	Kum	204		22	22 Wiscon	nsin Ave	., N.W.	Wash.	, D.C.	20007
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that cone cause on e	aused the deat	th. Do not ente	er the mode of dyin	g, such as cardia	c or respiratory a	rest,		Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition	Arte	rioscle	rotic '	Vascular	Disease				Onset and Death Years
	/Medical Examiner		resulting in death)	и	or as a consec							70020
	LAGITITIE	L.	Sequentially list conditions,	b								
	ed sit	lne	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	(uence of):						
	xecut and II-trar	Examiner	that initiated events resulting in death) Last	c. Due to (	or as a conseq	uence of):		_		_		
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687		edical		a.								
Вох	The law requires that the death certifite has been signed by the attending tage 2 should be detached for use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out						25	3d. Date of deliv	/BIV
m	death e atte d for	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregn	irth 2 Feta ant at time of d		Ectopic pregnancy Other (specify)				Month	Day Year
0.	t the by the ache	hys	9 ☐ Unknown	9□ Unkno	own							
	res tha igned be det	by P	Part II. Other significant conditions of	ontributing to de	eath but not res	sulting in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco us	e contribute to	the cause of death?
ğ	w require been sig should b								101	∕es 2🛚X	No 3□Pro	bably 4 Unknown
Vital Records,	has be	Completed							24a. Was		24b. Were aut	opsy findings available
<u>~</u>		Com							autor perfo	rmed? 2 X No	death?	ompletion of cause of
ita	ilcien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?					26. Place of De	ath (Check only o			
7		9	1 ☐ Yes 2 🔀 No	Hospital: 1 □ I	npatient 2	ER/Outpatien		4   Nursing r	Home 5 Resid	dence 6	Other (Speci	ify) Asst. Liv.
U C	or Attending Phater death. Director; After thin by the funeral	on:	27. Manner of Death  1 X Natural 5 ☐ Pending	28a. Date (Mont	of Injury th, Day Year)	28b. Time of Injury	28c. Injun Work		28d. Describe h	now injury	occurred	
<u>S</u>	death. ctor; A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be	-				Yes 2 □ No				
Division of	l or Attendater death Director:	Certification:	4 Homicide determined	280. Place	of Injury - At hing, etc. (Specif	ome, tarm, stre by)	eet, factory, office		28f. Location (S City or Tox		Number or Rui	al Route Number,
	spitel		29a. Certifier 1X Certifying Phy	veician: To the	hest of my kno	wledge death	and used at the time	a data and alas				
	To the Hospitel or At within 24 hours after or To the Funerel Direct completely filled in by	edical	(Check only 2 Medical Examone)	iner: On the ba	asis of examina	ation and/or inv	restigation, in my of	oinion, death occi	urred at the time,	date and p	place, and due	stated. to the cause(s)
	To th within To th	Me	29b. Signature and title of certifier	2 1 1	, 1		29c. License	number		29d. Date	signed (Month,	, Day, Year)
)	12		Muchael	4/4	roses		MD15	901		Jan.	30, 20	06
	1	1	30. Name and address of person who d	Apleted caus	e of death (Iten	n 23a) (Type, I	Print)					
	Life		Michael J. Grady,					W. Wash.	, D.C. 2	0016		
	Sta Registr	-	31. Date filed (Month, Day, Year) FEB 0 1 2	006	egistrar's Signa	A A	all!					
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			. Auciki itt	sii 23a per	Dr.,Go	Certifica	te of	Death		Rag. No.	JU6	04390	j
			1. Decedent's Name (First, Middle, Le						2. Date of De	eath		3. Time of Death	
	Physici		Mary L De	mottez					Januar	y 30,	2006	12:50 PM	
	/Medi Examir		4a. Facility Name (If not institution, giv	e street end number)				4b. City, Town,	or Location of Deat		ounty of Deat		
			Beverly Health Ca	re Center				Hagerst	own	Was	hingto	n	
	<sub>c</sub> Funeral		Social Security Number     6. 5		(In yrs. lest bir	Month	er 1 Yea		Hrs. 8. Date of Bi	rth av. Year)	9. Birt	hplace (State or Foreiguntry)	gn
	Director		217-12-1890 Usual Residence of Decedent	□ M 2 <b>/X</b> F	92	Yrs.			May 10	, 191	3 Hag	erstown, M	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Mcclical Examiner must be ricitled at	5	10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limit	
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	with a or	ក់								_	en of What Co	untry r	
	eath	erai	464 McDowell Ave.	12. Was Decedent E	ver in II S		1740	Hispanic Origin?	(Specify Yes or No	U.S	. A . I. Race - Ame	rican Indian	
	fter d	F	1 Never Married 2 Married	Armed Forces?  1  Yes 2 No. 1 Yes, Give		If Yes, sp	ecify Cu	ban, Mexican, Pi	uerto Rican, etc.)		Black, White		
070	urs a al', o Exan	by	3 ☐ Widowed 4 ☐ Divorced	ff Yes, Give Year or Dates:		1 ☐ Yes	2 XN	Specify:		5	pecity: Wh	ite	
5-0	72 ho natur	eted	15. Decedent's Ed (Specify only highest gre		16a.	Decedent's Us (Give kind of w	ual Occu	upation e during most of ed)	working	16b. Kind	d of Business/		_
Maryland 21215-0020	should be filed within 72 hours after death with the Marylan of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	Completed	Elementary/Secondary (0-12)	College (1-4or 5-		` <i>ite. DO NOT</i> nemaker	use retir	ed)		Dome	etic		
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lan	should be I and Mental I s marked of umatic eve	To Be	Dominic DeMott	ez				Mable	Shaffe	r			
ary	2 shou and M is mar aumat	-	19a. Informant's Name/Relationship (	Type, Print)	19b	. Mailing Addre	ss (Stree	et and Number of	r Rural Route Numb	er, City or	Town, State, 2	(ip Code)	
	nd 2 lith a 27 is		Isabelle Marani		8.	l High	Ridg	e Road I	Delta, Pe	nnsyl	vania	17314	
ore	of Head of Head it of the		20a. Method of Disposition		20b. Place of cemeter	Disposition (No. crematory or	eme of other pla	ace)	Date	20c. Loca	ation - City or	Town, State	
Ĕ	Pages nent of int: if its		1 ☐ Burial 2 <b>⑤</b> Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Smiths	sburg C	rema	tory	1/31/06	Smith	sburg,	Maryland	
Baltimore,	permit. Pages Department of important: if it any injury or once.		21. Signature of Funeral Service Licer	isee					Rest Have				
<b>m</b>	8 2 2 8 8		S. Mark Si	·								yland 2174	2
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused to	the death. Do	not enter the mo	de of dy	ing, such as car	diac or respiratory a	rrest,		Approximate Intervel Between	
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	icate be executed physician and s the bunal-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		oue of (or as e	consequence of	):						
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89	certificate be executed iding physician and ise as the burial-transit	B	resulting in death) Last	D	ue to (or as a c	onsequence of	:						
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P.0	law requires that the death as been signed by the atter s 2 should be detached for u	Physiciar	· Osu	chosis	With	De.	nei	itia	1□	Yes 2□	No 3⊡Pr	obabiy 4 Onknor	٧n
	res th	ρ		chosis pertes									_
Ö	v require been si should t	eted	/ He	pecles	Sun					an autopsy ormed?	8	Vere autopsy findings vailable prior to ompletion of cause	
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ᇤ	ate pag	Ö							10	Yes 2₽	No 1	☐Yes 2☐No	
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of	this aldi	. To	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Inpatien 28a. Date of Injury			UA	4 LI Nursin	g Home 5 Resi			ify)	
on	ding I h. After funer	tion	1 ■ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day		njury M	28c. Inju Wo 1 [	ork? ]Yes 2 □ No	202. 2000.120		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
Division	i or Attending after death. Director: After d in by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injur		rm, street, facto	ry, office				Number or Ru	ral Route Number,	
á	after Dire	Certification:	4 Homicide	building, etc.	(Specify)				City or To	wn, Stete)			
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical (	29a. Certifier 1 Cartifying Ph	ysiclan: To the best of linar: On the basis of e	my knowledge	death occurred	at the t	ime, date and pla	ace, end due to the	cause(s) ar	nd manner as	stated. to the cause(s)	
	To the H within 24 To the F complete	Medi	one)	and manner state	ed.								-
	5 d <u>ki</u> 7	-	29b. Signature and title of certifier	y lead.	-		2	se number		Zad. Date:	signed (Month	, vay, 10al)	
			- 1-00				ν-	1010		1	,		
			30. Name and address of person who of FRANCES	completed cause of dea	10 (Item 23a) (	Type, Print)	317	mies	8 #	appe	tons.	MD	
	Sta	te	31. Date filed (Month, Day, Year) FEB 1 5 2006	1	's Signature	matter 1	,40		/0	J	, [	, -	
	Registr		FEB 1 5 2006	District of	a figure	Die and The same				•			

			1 - For State Registrar	State of Mary			of Health of Deal			giene Reg. No.	006	04391
r*le	Physici		Decedent's Name (First, Middle, Last     ALBERT		JNN				2. Date of Dea Month ANUARY	Day	2006	3. Time of Death 3:12 A M
	/Medio Examir		4a. Facility Name (If not institution, give MONTGOMERY GENERAL	street and number) - HOSPITAL		4b. City, To	own, or Location		AHUAKT	4c. C	County of Dea	ath
	Funeral Director		5. Social Security Number  089-03-2060  Usual Residence of Decedent		yrs. last birthday)	If Under 1 Months (		der 24 Hrs. g	3. Date of Birt (Month, Day JUNE 1	h y, Year) 1913	9. Bi	rthplace (State or Foreign country) NNSYLVANIA
	e Maryland a-f ehow	ctor	10a. State 10b. County  MARYLAND MONTGOMI		C. City, Town or LO							10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	with the	Dire	10e. Street and Number 531 RANDOLPH ROAD			10f. Zip C					on of What C	country?
9036	2 hours after death with the Maryland satural', or Items 23a or 28a-f ehow gal Examiner must be invittled at	d by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: W			nt of Hispanic Cuban, Mexi	Origin? (Spec can, Puerto Ri ify:	ify Yes or No- ican, etc.)	- 14	Black, Wh	encan Indian, ite, etc. WHITE
21215-0036	within 72 ene. then "nai	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation le completed) College (1-4or 5+)	16a. Dece (Give life.		Occupation done during n retired)	nost of working	7		of Business	,
Maryland 2	ould be filed Mental Hygi- arked other atic event, I	To Be C	17. Father's Name (First, Middle, Last) LEE DUNN					other's Name (	First, Middle,	Maiden S		
	s 1 and 2 should if Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T) RENETTE OKLEWICZ  20a. Method of Disposition		1192	7 TRIF	LE CRO	WN ROA	D, RES	TON,V	IRGIN	Zip Code) IA 20191 r Town, State
Baltimore,	Pages ment of ant: If It ury or o		1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,		Ob. Place of Dispo cemetery, created the ATIONAL	CREMAT		01/31,	/2006	FALL	S CHUF	RCH, VIRGINIA SERVICE
Ba	permit. Departi Importi eny Inj		with substition	- Sul	7	400 LE	E HIGH	WAY, FA	ALLS CH	IURCH		
-	Physician /Medical Examiner	_	23a. Part1. Enter the disease, or comp shock, or heart failure. List only of mmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	invalidations that caused the ne cause on each line.  a.	Piraton nsequence of): munity	A A Q U	rresilved	st	MO n			Approximate Interval Between Onset and Death
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.O. Box 6	that the death certificated by the attending phase detached for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pr 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic preg Other (spec				23	d. Date of de Month	elivery Day Year
rds, P.	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions co	,		nderlying cau	se given in Pa	art I.	23e. Did to		,	to the cause of death?  Probably 4 Unknown
of Vital Records,	The ate h page	Completed	Atrial Fibi	-illatio	n.				24a. Was autop perior 1 Yes	sy	24b. Were a prior to death?	
Zit:	Physicien: Tr this certificate ral director, pag	To Be	25. Was case referred to medical examiner?	Hospital: Inpatient	2 ER/Outpatier	nt 3 DOA	Other	ace of Death (			Other (Sa	og/h/l
	ling After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time o		i. Injury at Work? 1 ☐ Yes 2	28	8d. Describe h			<del>oc</del> ny)
Division	i ji fe o	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, stipecify)	reet, factory, o	office	28	Bf. Location (S City or Tow		Number or F	Rural Route Number,
	Hospitel 24 hours a Funerel C etely filled	edicai	29a. Certifier (Check only one)  1 Certifying Phy 2 Medical Exam	sician: To the best of my ner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at vestigation, in	the time, date my opinion, o	and place, and death occurred	d due to the d	cause(s) a date and p	nd manner a	as stated. le to the cause(s)
	To the Comple	Me	29b. Signature and fittle of ceptifier	OHIKI	CIANI	1 0	icense numb	er (E)		29d. Daje	signed (Mar	oth, Day, Year)
0	(5)		30. Name and address of person who comes SHYAM PARKHIE M.I		(Item 23a) (Type,	Print)	0,0	NFV 1	ΜΔΡΥΙΛΙ	MD 20	1832	
35.5	Sta Registi		31. Date filed (Month, Day, Year)  JAN 3 1 2006	Registrar's S		<u>. 5. 1                                 </u>	TAT O	<u></u>	i a uvi LAi	LU LU	,502	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day LUNA DIAMOND 28, 2006 JANUARY 10:00P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SUMMERVILLE ASSISTED LIVING **POTOMAC** MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 21 F Months Days 578-30-7043 90 Director 01/02/1916 NEW YORK Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show iral, or items 23a or 28a-f shore Exeminer must be notified at MARYLAND MONTGOMERY POTOMAC 1 XYes 2 □ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11215 SEVEN LOCKS ROAD 20854 U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No WHITE δ Specify: Specify 3 XWidowed 4 ☐ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Efementary/Secondary (0-12) College (1-4or 5+) SECRETARY GOVERNMENT othar traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental I Pages 1 and 2 should be nent of Health and Mental SOLOMON EREZA SARAH SEMEH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
important; if item 27 Is
eny injury or other trau MONTY DIAMOND/SON 140 WEST 4TH STREET, NEW YORK, NEW YORK, 10012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3X Removal from State KING DAVID MEML GDNS 02/01/2006 FALLS CHURCH, VIRGINIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundral Sapa 22. Name and Address of Facility
DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Part. Errier the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ASPIRATION PNEUMONIA /Medical Due to (or as a consequence of) Examiner DYSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed CEREBRAL VASCULAR ACCIDENTS, MULTIPLE Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1☐Live birth 2☐Fetaf death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FEEDING GASTROSTOMY TUBE 1 ☐ Yes 2√2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? PARKINSON'S DISEASE 24a. Was an autopsy performed?
Yes 2 12 No 2 No 1 Yes 1 🔲 Yes To Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 ☐ Yes 2 ☐XNo 1 Inpatient 2 ER/Outpatient 3 DOA Director: After th 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNaturat Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Dire 1 A Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month, Day, Year) D35579 JANUARY 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUSAN J. MILLER, 6844 TULIP HILL TERRACE, BETHESDA, MD 20816 31. Date filed (Month, Day, Year) Registrar's Signature State 2006 Registrar

			1 - For State Registrar	State	of Marylar	nd / Depa	artment of I tificate of	lealth an Death	nd Mental Hy	ygienē Reg. No.		04393	
н	Physici	an	1. Decedent's Name (First, Middle						2. Date of D Month Janua		∠Year	3. Time of Death	
	/Medic		Sylvia Louise								7, 2006	4:18 p M	
	Examin	er	4a. Facility Name (If not institution	•	ımber)		4b. City, Town,		Death	4c.	County of Deat		
			Holy Cross Hos  5. Social Security Number	6. Sex	7 Age (In vrs	. last birthday)	Silver If Under 1 Year		Hrs. 8 Date of B	irth	Montgo		
	Funeral Director		577-16-5036	1 □ M 2 🖺 F	8		Months Days		Min. 8. Date of B (Month, D Nov • 1	ау, Year) 5. 19	918 Ok]	nplace (State or Foreign untry) ahoma	
	ъ		Usual Residence of Decedent										
	show	_	10a. State 10b. County			ity, Town or Lo					10d. Inside City Li		
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21215-0036	permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event. It a Medical Examinar must be notified at once.	by Funeral Directo	Narital Status     Never Married 2⊠ Married 3 □ Widowed 4 □ Divorced	ied Armed F	orces? 2[X]No ive	1	f Yes, specify Cub	an, Mexican, F	Puerto Rican, etc.)		Black, White	e, etc.	
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פ	be file	Be	17. Father's Name (First, Middle,						Name (First, Middle		Sumame)		
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Maryland	12 sh h and h and 7 ts m		19a. Informant's Name/Relations Floyd A Day/ Ht						or Rural Route Num. #CAO6			ip Code)	
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و	S S E E		1 ☐ Burial 2 ☑ Cremation		Sidle		sition ( <i>Name of</i> natory or other pla an <b>Cremat</b> o	No an	nuary 31		•		
Baltimore,	artme artme ortani injury		4 ☐ Donation 5 ☐ Other (S 21. Signature of Funeral Service		FIC	-				Allia		Virginia	
ñ	Dep find any		· allh	J By	?						Spring	, MD 20901	
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X Q Q	death certif e attending id for use as	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?	1 Live	birth 2 Fet nant at time of	al death 3□	Ectopic pregnanc Other (specify)	у		1	23d. Date of deli Month	very Day Year	
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 T	requires that the een signed by th hould be detache	by Pł	Part II. Other significant condition	ons contributing to	death but not res	sulting in the ur	nderlying cause gr	en in Part I.	23e. Did	tobacco u	ise contribute to	the cause of death?	
ras,	w require been sig should b		Dehydration						_ 10	Yes 2	□No 3□Pro	bably 4 JUnknown	
ecor		Completed							24a. Wa		24b. Were au	topsy findings available	
ř	sician: The law certificate has b irector, page 2 s	EO							per	opsy formed? 2 No	death?	ompletion of cause of 2□ No	
	ilan:	Bec	25. Was case referred to medical examiner?		-			26. Place of	Death (Check only				
>   	- W T3	Tof	1 ☐ Yes 2 🖾 No	Hospital: 1	Anpatient 2□	ER/Outpatien	t 3□ DOA Ot	ner: 4 🗆 Nursii	ng Home 5 ☐ Res	sidence (	6 □Other (Spec	ufy)	
<u> </u>	ding Phy h. After thi tuneral c	on:	27. Manner of Death 1 △ Natural 5 □ Pendin	28a. Date (Moi	of Injury oth, Day Year)	28b. Time of Injury	28c. Inju Wo	ry at rk?	28d. Describe				
<u> </u>	r Attendi er death rector: A by the fi	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	gation				Yes 2□No		(a)	<del></del>		
DIVISION	5 ± = C	Certification:	4 Homicide determ	ined 28e. Plac build	e of Injury - At r ling, etc. (Speci	iome, farm, stri fy)	eet, factory, office		28f. Location City or To	(Street and Swn, State)	d Number or Ru )	ral Route Number,	
	Fu P P	edical	29a. Certifier 1 Certifyin (Check only one) 2 Medical	Examiner: On the I	e best of my knoossis of examination of examinations of examinations of examinations of the examination of the exam	owledge, death ation and/or inv	occurred at the ti restigation, in my	me, date and popinion, death	place, and due to the occurred at the time	cause(s) , date and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	ž	29b. Signature and title of certifie		/		29c. Licens			29d. Dat	e signed (Month	, Day, Year)	
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,			30. Name and addres of person Suresh K. Gupta	who completed cau	se of death (Ite	m 23a) (Type,	Print)	220 5	ilver Spr	ina	MD 2090	12	
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	Sta		31. Date filed (Month, Day, Year)	2006	Registrar's Sign	LI And	all I						

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Feb. 2006 0615 A M Alice Fay DeVore /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 763 Cushman Avenue Cascade Washington If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 12/25/1954 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔀 F 51 Director 215-64-0564 MD Usual Residence of Decedent fited within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f show rother traumetic event, the Madical Examinar must be notified at 1 XYes 2 No MD Washington Cascade **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21719 763 Cushman Avenue US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2⊠ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: White Be Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. int: if Item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Helen Louise Gerhold Lewis Jacob Hose, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 758 Cushman Avenue, Cascade, MD 21719 Stephen D. DeVore, Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
1 ☐ Donation 5 ☐ Other (Specify) 5 permit. Page Department of important: if any injury or once. Smithsburg Cremator. 02/04/2006 Smithsburg, MD 21. Signature of Eunoral Service Lia 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MUOCZVa /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, hary, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy ō in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) Yes 2 No page 2 should be detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has 1 Tes 2 No Physician: 25. Was case referred to medical examiner? the funeral director, 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Pasidence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 - Homicide To the Hospital Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) erson who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of M	faryland / De	partment of ertificate o			Re	g. No.	06.0	)4395
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	/Medic Examin	al	Paul Stephen DeVo 4a. Fecility Name (If not institution, give 763 Cushman Avenu	street and number	r)	4b. City, Town	_		Jaii.	4c. Cou	inty of Death shingt(	1
	Funeral Director		219 74 2404	7. A	Age (In yrs. last birthda 55 Yrs.	Months Davis House Mis			Date of Birth (Month, Day, 1/04/19	Year) 950	9. Birthpl Coun	lace (State or Foreign try) WV
	Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  MD Washingt	con	10c. City, Town or Cascad						10	0d. Inside City Limits 1 ŽYes 2 ☐ No
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980	within 72 hours after death with the Maryland ene. Itan "natural" or llems 23a or 28a-f show ta Medical Examinar must be molified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 ★ Married  3 □ Widowed 4 □ Divorced	12. Was Deceder Armed Forces 1 ⊠ Yes 2 ☐ If Yes, Give Year or Dates	11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	3. Was Decedent of If Yes, specify Control of Image of I		gin? (Specily n, Puerto Rici	an, etc.)	1	Black, White, o	etc.
Maryland 21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene. Id other than "natural; or liems 23a or 28a-f show or other than "natural; or liems 23a or 28a-f show event, the Medical Examinational barrolling at	Completed by	15. Decedent's Ec (Specify only highest gra	ucation de co <i>mpleted)</i> College (1-40	(Gi	cedent's Usual Occ ve kind of work do b. DO NOT use ret None	ne during most	t of working	1	6b. Kind o	of Business/Inc	dustry
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, Mary			19a. Informant's Name/Relationship (Alice F. DeVore		19b. Ma 763	o Cushman	Avenue	e, Cas	cade, 1	1D 21	719	
Baltimore,	permit. Pages 1 and Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition  1 Burial 2 Toremation 3   4 Donation 5 Other (Specify		te cemetery, c	sposition (Name of rematory or other parts)				Smith	sburg,	MD
Balt	permit. Departi Importi any inj		21. Signature of Funecal Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral 305 N. Potomac Street, Hagerstown, MD 217									
	Fnysician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):										Approximate Interval Between Onset and Death
8760,	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burlat-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or a	as a consequence of);							
P.O. Box 6	that the death certifical led by the attending phote detached for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No		2 ☐ Fetal death at time of death	3 □Ectopic pregna 5 □ Other (specify)				23d.	Date of delive Month	ery Day Year
	quires lhat n signed t uld be dett	by	Part II. Other significant conditions of	ontributing to death	but not resulting in the	underlying cause	given in Part I			accouse d s 2 □ N		ne cause of death?
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Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  ↑  Yes 2 □ No	Hospital:	atient 2 🗍 ER/Outpa	am and	Othon	of Death (Cursing Home	Check only one		Other (Specify	
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Division	al or Atter s after dea il Director id in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	200. Flace 01	Injury - At home, farm, etc. (Specify)	street, factory, offic	Ce TT	28f	Location (Str City or Town	eet and Ni , State)	umber or Rura	I Route Number,
	ne Hospital n 24 hours a ne Funeral I	Medical (	29a. Certifier (Check only one)	ysician: To the be niner: On the basis and manner	st of my knowledge, de of examination and/o stated.	eath occurred at the r investigation, in m	e time, date an ny opinion, dea	nd place, and ath occurred	at the time, da	ite and pla	ce, and due to	the cause(s)
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1 A/	1-5+1		30. Name and address of person who		of death (Item 23a) (Type of A 1 + +	pe, Print)	Har	+	MA	2174	2	
	Sta Regist		31. Date filed (Month, Day, Year) FEB 0 2		strar's Signature	Spear		,,,,,,,,,	/ · · · · ·	- 11		

State of Maryland / Department of Health and Mental Hygiene For State State RegistrarAmended item #29d per wichd/*Certificate of Death* 02-01-2006 death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wichd/Certificate of Death 62-01-2006 of the RegistrarAmended item #29d per wich 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Month Parks Dise 30,2006 Vanessa anciery /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kennsula Legional Medical 5. Social Security Number 6. Sex 7. Ag Cente NICOMICO If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Virginia 8. Date of Birth (Month, Day, **Funeral** Days Months 1 M 2 XF Hours Min. April 8,1952 Director 53 216-64-8267 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show the Microsoft Examiner must be notified at 1 XYes 2 No Tangier Virginia Accomack Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 23440 USA 16632 West Ridge Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: à 3 Widowed 4 Divorced White "nature!". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic rmit. Pages 1 and 2 should be titled wit spartment of Health and Mental Hygient portant: If item 27 ie marked other thu y injury or othar traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard Parks Fave Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry Dise/Husband 16632 West Ridge Road Tangier, Virginia 23440 Baltimore. 20b. Place of Disposition (Name of cemejary, crematory of other place)
New Testament Church
Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Tangier, Virginia 02/02/06 21. Signature of Funeral Service License 22. Name and Address of Facility
Williams Funeral Home but kremoc <u>25046 Parksley Road, Parksley, Virginia 23421</u> 23a. Part1. Enter the disease, or complications that caused the letth. Do not enter that de of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the a detached f P.O. 9 Unknown signed t Part II. Other significant conditions contributing/to/death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records. 3 ☐ Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No After this certificate has been si funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy of Vital 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA ဥ 1 Impatient 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending death. М 1 ☐ Yes 2 ☐ No investigation 2 Accident i or Attend after death Director: the 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 🗌 Homicide To the Hospital within 24 hours a To the Funeral D TCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier 29b Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/30/06 30. Name and address of person who impleted cause of death (Item 23a) (Type, rint) ( M.D. 1340 S. DIVISION KHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar FEB 0 1 2006

		•	For State Registrar	State of	Maryland /		artmen <i>rtificat</i>			and M		giene Reg. No.	106	04397
П	Physicia	an	1. Decedent's Name (First, Midd								2, Date of Dea Month	_	Year	3. Time of Death
	/Medic	al	Helen K. Ele								Februar	1	2006	10:50 A <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution				1		Location of				ounty of Dea ntgome	
			Manor Care  5. Social Security Number		e 7. Age (In yrs. last	hirthday)	If Under		y Cha	24 Hrs.	8. Date of Birt			
	Funeral Director		072-12-2670	1□M 21 F	94	Yrs.	Months	Days	Hours	Min.	Mar.6, I	911	Ge	thplace (State or Foreign buntry) YMany
	D.		Usual Residence of Decedent											
	arylar show	<u>.</u>	10a. State 10b. County	,	10c. City, To	own or Lo	ocation							10d. Inside City Limits 1X Yes 2 □ No
	he M	ecto	D.C.	None	Wash	ingt	ton	0-1-			1	10- 011	n of What Co	
	a or 2	Funeral Director	4222 Brandywi	ne St N	ī <sub>a</sub> T		10t. Zip		0016			rog. Citize		•
	heath	era	11. Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Deced			gin? (Spe	ocify Yes or No-	14	U.S.A	
ယ္	or Iter		1 ☐ Never Married 2 ☐ Mar	ned For	ces? 2 <b>[2</b> 0No					i, Puerto	ecify Yes or No- Rican, etc.)		Black, Whit	te, etc.
03	n 72 hours after death with the Maryland "natural", or Items 23a or 28e-f show cotcal Examinor must be notified at	d by	3 → Widowed 4 Divorce	If Yes, Give	etes:		1 Yes	2121-NO	Specify:			S	pecify: W	hite
5-0	72 h "natu	Completed	15. Deceder (Specify only higher	nt's Education est grade completed)	11	6a. Dece (Give	dent's Usua kind of wo	al Occupa	ation during mos	t of work	ing	16b. Kind	of Business	/Industry
121	d within glene.	du	Elementary/Secondary (0-12)	College (1	4or 5+)	<sup>//fe.</sup> (	Jwn H	se retired OME	)			Ow	n Home	2
d 2	filled Hygi ther		17. Father's Name (First, Middle,	Last)	1			1	18. Mothe	er's Name	(First, Middle,	Maiden St	umame)	
lan	should be nd Mental marked c	To Be	Unava	ilable				İ		U	nava <b>i</b> la	ble		
ary	2 should and Men Is marke aumatic		19a. Informant's Name/Relation	ship (Type, Print)	onal 1		_				al Route Numbe			
Σ	s 1 and 2 of Health a item 27 Is other trai		Robert A. Gazz	ola/ Repre					, Sui					
Baltimore, Maryland 21215-0036			20a. Method of Disposition 1 □ Burial 2 □ Cremation	3 Removal from S	ceme	itery, cre	osition (Nar matory or o	ther plac	θ)	Fel	Date 7,		ition - City or	
ţim	tmen tent: tent:		'4 □Donation 5 □ Other (		Metr		itan						lex.,	Va.
Bal	permit. Page Department of Importent: If any Injury or once.		21. Signature of Euneral Service	De Val	1						Vol Fune			C 20007
ı			23a. Park. Enter the disease, of shock, or heart failure. Lis	r complications that ca t only one cause on ea	aused the death. Each line.	o not en	ter the mod	le of dyin	g, such as	cardiac o	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Pnysician	. 1	Immediate Cause (Final disease or condition resulting in death)	a Seps	sis									1 week
	/Medical Examiner	1	resulting in death)	Due to (	or as a consequen	ce of):								
		e e	Sequentially list conditions, if any, leading to immediate	b. Due to (	or as a consequen	ce of):								
V	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	<b>{</b>										
o,	death certificate be executed e attending physician and id for use as the burial-transit		resulting in death) Last	Due to (	or as a consequen	ce of):								
8760,	icate be ex physician s the buria	Physician/Medical		d										
9	ertifica ling pl	Med	IF FEMALE:											
Box	eath certific attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	1 ☐Live bi	come of pregnancy rth 2 Fetal dea ant at time of death	ath 3[	Ectopic pr					23	<li>d. Date of de Month</li>	livery Day Year
o.	at the de by the a tached	ysic	1 □ Yes 22 □ No 9 □ Unknown	9□ Unkno		ו סנ	Other (sp	өспу) <u> </u>						
Δ.	requires that the een signed by th hould be detache		Part II. Other significant condit	ions contributing to de	ath but not resultin	g in the u	ınderlying c	ause give	en in Part I.		23e. Did to	bacco use	contribute to	the cause of death?
rds	quires n sign uld be	ed by	Deculittii								1 🗆 ነ	'es 2 🗆	No 3□P	robably 4X Unknown
Vital Records,	aw requir as been si 2 should	Completed	Osteoperosi	s							24a. Was		24b. Were a	utopsy findings available completion of cause of
Ä	The lage age	mo;										med?	death?	
'ita	ician: certifical	Be	25. Was case referred to medical examiner?	al _					26. Place	of Deatl	n (Check only o	ne)		
of V	Physician: this certific ral director,	은	1 ☐ Yes 2 🛣 No		npatient 2 ERV	_			442 140		me 5 Resid			icify)
	ling After funer	ertification;	27. Manner of Death 1 Natural 5 ☐ Pendi	9	f Injury 28 h, Day Year)	b. Time o Injury	of 2	28c. Injun Work	/at <br Yes 2. □		28d. Describe h	iow injury o	occurred	
Division	ten leat tor: the	icat	3 Suicide 6 □ Could		of Injury - At home	farm st			162 2	in the	28f Location (5	Street and I	Number or R	ural Route Number.
DΪ	al or At s efter d il Direct id in by	Certif	4 ☐ Homicide deter	buildir	ng, etc. (Specily)	, rann, st	root, ractory	y, onloc			City or Tou			
	To the Hospital or a within 24 hours efter To the Funeral Direction completely filled in b	edicai (	29a. Certifier 1 Certifyi (Check only one) 2 Medica	ng Physician: To the Examiner: On the ba and mann	isis of examination	dge, deat and/or in	th occurred ivestigation	at the tim , in my of	ne, date an pinion, dea	id place, ith occurr	and due to the red at the time,	cause(s) ar date and p	nd manner as lace, and due	s stated. e to the cause(s)
	To the comp	M	29b. Signature and title of certific	or DP	0		290	. License	number	2			_	th, Day, Year)
•			▶ /\lune	h K CC	U!			110	160	1		2.8	5.06	
	5		30. Name and address of person Raman R. Tul	i, M.D., 1	0810 Dar	nest	OWB R	oad	#202,	, Gai	thersbu	ırg, l	Md. 20	878
	Sta Registr		31. Date filed (Month, Day, Year FEB 1 5	2006	egistrar's Signature	Page 1								

			1 - For State Registrar	State of Ma			ent of He	ealth and		giene	6 01:3	98
Ŕ	Physic	- 8%	1. Decedent's Name (First, Middle, La	ist)				.,	2. Date of De		3. Time of	Death
1 the 1	/Medi		Margaret Edmonds	on					01	~ ~ ~	306 1531	Õ M
	Examir	ier	4a. Facility Name (If not institution, give		/	4b. C	ty, Town, or	Location of Dea	ith O	4c. County o	1	
		STATE OF	5. Social Security Number 1 6.5		(In urs last	hirthday) If Un		If Under 24 Hr			O Birthniana (State e	
В	, Funeral Director			1 □ M 2 🏝 F	(In yrs. last 74	Yrs. Month		Hours Mir	(Month D	7, 1931 W	9. Birthplace (State of Country) Vest Virgi	nia
	р .		Usual Residence of Decedent							,		
	anylar show	-	10a. State   10b. County   Maryland   Prince G			own or Location					10d. Inside Cit	-
	he M	ecto	10e. Street and Number	eorge	rores		7. 0 .				1. <b>∑</b> Yes	2 [ NO
	with Sa or	ğ	6104 Surrey Squa	re Lane Apt	t. 103	)	Zip Code 20	0747		10g. Citizen of Wh United S		
	72 hours after death with the Maryland naturel', or tems 23a or 28a-1 show pical Examinar must be codified at	by Funeral Director	11. Marital Status	12. Was Decedent Ev			cedent of His	spanic Origin? (	Specify Yes or No	- 14. Race	- American Indian,	
9	or Ite	F	1 ☐ Never Married 2 2 Married	Armed Forces?	0		pecify Cuban i 2 <sup>™</sup> No		Specify Yes or No rto Rican, etc.)		, White, etc.	
21215-0036	ours Irel',	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:						Specify:	Black	
5	"natu	Completed	15. Decedent's E (Specify only highest gro		1	6a. Decedent's U (Give kind of life. DO NO	sual Occupat work done du	tion uring most of we	orking	16b. Kind of Bus	iness/Industry	
12	within ene. then "	щ	Elementary/Secondary (0-12)	College 21-4or 5+	-)	Supervi				Privat	:e	
	d be filed on the hold of the control of the contro	Be	17. Father's Name (First, Middle, Last William Wick						ame (First, Middle 1 Brown	, Maiden Surname,	)	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or Items 23s or 28s-1 show any Injury or other treumatic event, the Medical Examinat must be notified at ance.	스	19a. Informant's Name/Relationship ( Eli Edmondson, J		16	19b. Mailing Addre	ess (Street ar	nd Number or F uare Ln	Rural Route Numb	er, City or Town, Si 03 Forest	tate, Zip Code) Eville, Md	20747
Baltimore,	Pages 1 an nent of Heal ant: If Item 2 ury or other		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □	Removal from State	20b. Place ceme	of Disposition (f	vame of or other place	)	Date 3, 2006	20c. Location - C	ity or Town, State	
Ħ	artmer artmer prtant Injury		4 ☐ Donation 5 ☐ Other (Special Signature of Fane)al Service Lices		Mary	and Vete	and Address	1		eral Home		
Ba	permit. F Departme Importar any Injur		1191	8	11	d	and 7.001.035		5538 Mar	lboro Pik	ce 20747	
1 5	3		23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused to	the death. E	o not enter the m	ode of dying	, such as cardia	ic or respiratory a	rrest,	Approximate Interval Betw	)
	Physician		Immediate Cause (Final disease or condition	seve		Anem	in				Onset and D	
7	/Medical Examiner		resulting in death)	Due to (or as a		ce of):	0 -		• 10	4		
	Lxammer	_	Sequentially list conditions,	D	W 62	vas cu		or cre	cerm	^		
	ted	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a		√ 0~ 4	em	alis	فحمه			
<u>,</u>	execun n and ial-tra	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequenc	ce of):		^	44 .			
1760,	te be executed ysicien and e burial-transit	cail	(	d Anox	ار د	ence	plu	a sul	iden ease atty			
89			45.55444.5									
Box	ith ce itendii or use	by Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2			pregnancy			23d. Date		
0	the all	sici	1 Yes 2 No	4□Pregnant at tii 9□ Unknown	ime of death	5 Cther	(specify)			Month	h Day Y	ear
α.	that the side by detac	Ph	Part II. Other significant conditions of	contributing to death but	not resulting	n in the undertying	Cause diver	in Part I	23e Did t	obacco use contrib	ute to the cause of de	eath?
Division of Vital Records,	Attending Physicien: The law requires that the death certifica robath. crost After this certificate has been signed by the attending property the funeral director, page 2 should be detached for use as it						, saddo g d.				Probably 4 U	
000	law re as bea 2 sho	Completed							24a. Was		ere autopsy findings a	ıvaılable
Œ	The ate h	E							autor perfo	rmed? dea	or to completion of ca ath? ]Yes 2☐ No	use or
ita	Physicien: The lav this certificate has al director, page 2	Be (	25. Was case referred to medical examiner?						ath (Check only o			
of o	Physi this o	2	1 Yes 2 No	Hospital:		Outpatient 3		4   Nursing		dence 6 Other		
u	ding Ph h. After th funeral	lon	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of fnjury (Month, Day	Year) 28t	o. Time of fnjury M	28c. Injury a Work?	at es 2 ⊡No	28d. Describe I	now infury occurred		
ISI.	Attender deat	fical	2 Accident investigation 3 Suicide 6 Could not b	0 00 01 (1-)	y - At home.			93 2 1140	28f. Location (	Street and Number	or Rural Route Numb	ner
á	s after s after al Direct	Certification:	4  Homicide determined	building, etc.	(Specify)	, ,	-,, 55		City or Tov	vn, State)	or real and real and	
	To the Hospital or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical (	29a. Certifier (Check only one) 1 Certifying Ph	nysician: To the best of miner: On the basis of e and manner state	examination	lge, death occurre and/or investigati	ed at the time on, in my opi	e, date and plac nion, death occ	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as stated. d due to the cause(s)	
	To the within 2 To the complet	Ž	29b. Signature and title of certifier	neloth		2	9c. License	number		29d. Date signed (	Month, Day, Year)	
) _	2		) Jm	m. Abo	dell	CC ,	05	1481		1/25/0	6	
Æ	-(4)		30. Name and address of person who	completed cause of dea	ath (Item 23a	a) (Type, Print)	1001	N 1	21151-	ol, max	20785	
	Sta		31. Date filed (Month, Day, Year)	TODE IIA	's Signature	11 1105/21	THL	DKL	MEVER	cly mb	00185	
7	Sta Registr		JAN 3 1 2006	Blocke	A ,	fred						

			1 - For State Registrar		State o	of Man		ertificate of	Health and Death	Mental Hy		JUb	U4399
			Decedent's Name (First, M.)	iddle, Las	r)				Dout.	2. Date of De	Reg. No. eath		3. Time of Death
	Physic		Edmond I	Eller	bе					Janua	ry 25	Year 2006	12:24 A
	/Medi Examir		4a. Facility Name (If not instit	ution, give	street and nu	mber)		4b. City, Town,	or Location of Deat			ounty of Death	
	_xa,iiii	ic.	Prince Geo	orge'	s Hosp	ital		(	Cheverly		E	rince	George's
	Funeral		5. Social Security Number	6. Se		7. Age (1.	n yrs. last birthday	) If Under 1 Year Months Days		(Month D	rth ay, Year)	9. Birth	place (State or Foreig
ŀ,	Director		578-09-7302		XM 2□F		93 Yrs.			Mar. 7	, 1912	Nort	h Carolina
	land		Usual Residence of Deceden 10a. State 10b. Cou			10	Oc. City, Town or I	ocation					10d. Inside City Limit
	Mary -fah	ţō	DC					Washi	noton				1 ☐ Yes 2 ☐ N
	r 28a	Director	10e. Street and Number					10f. Zip Code			10g. Citize	n of What Cou	intry?
	h with	a D	514 - 2	23rd	Place,	N.E.			20002		Un	ited S	tates
	deat	Funeral	11. Marital Status		12. Was Dec	edent Eve	er in U.S. 13	. Was Decedent of	Hispanic Origin? (S pan, Mexican, Puer	Specify Yes or No	0- 14	Race - Amer	
0	or It		1 Never Married 2 1		1 ZYes	2 🗌 No		1 ☐ Yes 2 No		to mount etc.)		Black, White pec <i>ify</i> : B	, etc. 1ack
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	n 72 hours after death with the Marylan "natural", or Itams 23a or 28a-f ahow patical Examiner must be nuttred at	Completed	15. Dece (Specify only hi	dent's Edi ghest grad	ication le <i>completed)</i>		16a. Dec	edent's Usual Occu e kind of work done	pation a during most of wo ad)	rking	16b. Kind	of Business/Ir	ndustry
7	within ene. than "	E D	Elementary/Secondary (0-1	2)	College (	1-4or 5+)	1116.		ary Assis			Govern	ment
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yland		To Be	Azriah	E11e	rbe					Mo11:	ie Wal	.1	
3	ges 1 and 2 should be t of Health and Mental If itam 27 is marked or or other traumatic ev	-	19a. Informant's Name/Relati	onship (T)	/ре, Print)		19b. Mai	ling Address (Stree	t and Number or Ru	ural Route Numb	er, City or T	own, State, Zi	p Code)
Ž	and 2 salth a n 27 is	İ	Barbara S.	E11e	rhe/Wii	Fe			rd Place,				
ם נ	es 1 and 2 of Health fitam 27 i		20a. Method of Disposition				20b. Place of Disp	osition (Name of omatory or other plants	Cem.	Date		tion - City or T	
	Pages nent of ant: If it ury or o		1 □XBurial 2 □ Cremati 1 □ Donation 5 □ Othe	on 3.⊟F r <i>(Specify)</i>	Removal from	Jiano		n Nationa		1/2006	Ar1	ington	<b>.</b> VA
Dallinor	# 문문을		21. Signature of Furjeral Serv		- 7	D'		22. Name and Addre	1	Stewart			
Ŏ	permi Depar Impo any ir		mas/	1.	lewa	JI	11	4001 E	Benning Ro	d., N.E.	Wash	., DC 2	20019
	8. *		23a. Part1. Enter the disease shock, or heart failure.	, or <i>co</i> mp	lications that one cause on e	caused the	death. Do not e	nter the mode of dy	ing, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between
	Enysician		Immediate Cause (Final disease or condition	,									Onset and Death
	/Medical		resulting in death)		aDue to	(or as a co	ulmonary onsequence of):	Arrest					
	Examiner		Sequentially list conditions		Acu	ıte R	espirato	ry Failur	:e				
	po is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	1	Due to	(or as a co	onsequence of):						
	ificate be executed g physician and as the burial-transit	Examiner	that initiated events resulting in death) Last	1	c	/							
Ď,	oe ex	Ê	tooding in dodn't day		Due to	(or as a co	onsequence of):						
00/00,	physi the t	edical			d								
2	:= On m	/Me	IF FEMALE:		23c. If yes, out	teome of r	reonancy						
ם	atten for u	iclan/M	23b. Was decedent pregnant in the past 12 months?		1 Live b	oirth 2	Fetal death 3	□Ectopic pregnanc □ Other (specify) _	<b>у</b>		230	Date of delive Month	ery Day Year
į	the d y the	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		9☐ Unkn		0 01 000111 5	_ other (specify) _					
_	The law requires that the death certif ate has been signed by the attending page 2 should be detached for use a	₾.	Part II. Other significant con-	ditions co	ntributing to de	eath but n	ot resulting in the	underlying cause gr	ven in Part I.	23e. Did 1	tobacco use	contribute to t	he cause of death?
2	puires 1 sign 11d be	d by	Dementi	a, Di	labetes	Me1	litus, D	ecubitus	Ulcers,	1 🗆	Yes 2□N	No 3∏Prol	bably 4 Unknown
5	w req	ompleted	Periphe	ral V	Jacoula	r Di	CASCA			24a. Was	an 2	4b. Were auto	psy findings available
ב	he la e has age 2	ф	теттрие	ra.r	ascara	L DI	scase			auto perfe	psy ormed?	prior to co death?	impletion of cause of
	ifficati or, pa	CO	25. Was case referred to med	lical	-	-			26 Place of Dog	1 ☐ Yes ath (Check only		1 🗆 Yes	2∐ No
>	Physician: this certificatal director,	O.B	examiner? 1 ☐ Yes 2 ☑ No	-	Hospital:	Innatient	2 XEP/Outpatie	nt 3□ DOA Ot	hor	lome 5 ☐ Resi		Other (Speci	6/1
5	g Phy er thi	n: T	27. Manner of Death		28a. Date	of Injury	28b. Time	of 28c. Inju	ry at	28d. Describe			97
5	ath. r: Aft	atlo	1 Natural 5 ☐ Per 2 ☐ Accident inve	nding estigation	(IVIOITI	th, Day Ye	ea <i>r)</i> Injury		rk? ]Yes 2 □No				
2	f or Attanding Physician: The lavaler death.  Director: After this certificate has in by the funeral director, page 2.	Certification;		uld not be ermined	28e. Place	of Injury	At home, farm, s	reet, factory, office		28f. Location ( City or To		lumber or Run	al Route Number,
5	spital or ours afte narel Dir filled in	Cer	tond		Dalide					City or 10	····, Giale/		
	na Hospital or Attanding P n 24 hours after death. na Funarel Director: After t bletely filled in by the funera	dical	29a. Certifier 1  (Check only 2 Medi	fying Phy	sician: To the	best of m	y knowledge, dea	th occurred at the travestigation in mu-	ime, date and place opinion, death occu	, and due to the	cause(s) an	d manner as s	stated.
	o tha Hos ithin 24 h o tha Fun ompletely	Φ	Une)		and man	ner stated							
	0 = 0 =	Σ	29b. Signature and title of per	пер				29c. Licens	se number		29d. Date s	igned (Month,	Uav. Year)

To the Hospital o within 24 hours aft To the Funarel Di completely filled in State

30. Name and address of person with Teath (Item 23a) (Type, Print) Emmanuel Brown, M.D.

4302 St. Barnabas Rd., Suite B, Marlow Heights, MD 20748

29c. License number

MD 31152

29d. Date signed (Month, Day, Year)

January 26, 2006

JAN 3 1 2006

29b. Signature and title of

Registrar

			1 - For State Registrar	State of	Marylar	id / Depa		lealth and I	Mental Hygiei	29116	04400
Г	Physic	20	Decedent's Name (First, Middle	le, Last)					2. Date of Death	Day Year	3. Time of Death
	/Medi		Catherine	Fri					February	,	3.4
	Examir	ner	4a. Facility Name (If not institution				4b. City, Town, o	r Location of Death		4c. County of De	
			Millennium at				Edgewa			Anne Ar	
	Funeral Director		5. Social Security Number 139–07–5629	6. Sex 7. 1 ☐ M 2 💢 F	Age (In yrs. 92	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye.	ar) 9. B	irthplace (State or Foreign Country)
			Usual Residence of Decedent		92				3–23–191	3 Net	w Jersey
	how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation				10d. Inside City Limits
	e Ma	cto	Maryland Anne	Arundel		Annapo	lis				1 ☐ Yes 2X No
	ith th		10e. Street and Number				10f. Zip Code		10g.	Citizen of What 0	Country?
	e 23e	by Funeral Director	1249 Stillwood				21403			USA	
	iter de	Ë	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	12. Was Decede Armed Force ried 1 Yes 2	es?	.S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
336	urs af	by	3 ☐ Widowed 4 Divorced	WVan Cina	-	-	1□Yes 2XNo	Specify:		Specify: Tal	hite
0	be filed within 72 hours after death with the Maryland that Hyglene. Id other then "natural", or iteme 23a or 28e-f show event, the Medical Extraight hant be notified at	Completed	15. Deceden	it's Education		16a Deced	ient's Usual Occup	ation	16b	. Kind of Busines	
215	within 7 ene. then "r	nple	(Specify only highest Elementary/Secondary (0-12)	St grade completed) College (1-4	or 5+)	lite. L	kind of work done of OO NOT use retired	during most of world)	king		,
21	e filed within al Hygiene. I other then '	S	12th			Ope	erator			Telephor	ne
and	ould be fil Mental H arked otl atic svsn	Be	17. Father's Name (First, Middle,						ne (First, Middle, Maid	en Sumame)	
Ž	should be nd Menta marked imatic sy	ပို	100 Informantia Nama/Dalatiana	(unknown	,	401 14 11		<u>`</u>	unknown)		
Maryland 21215-0036	permit. Pages 1 and 2 should b Department of Health and Menis Important: If itsm 27 Is marked sny injury or other traumatic s ance.		19a. Informant's Name/Relations			1			ral Route Number, Cit	√or Town, State,	Zip Code)
	s 1 an Heal tsm 2		Helen M. Frix— 20a. Method of Disposition	Ross/Daughi	20b. P	lace of Dispos	sition (Name of	illwoods	Way, Anna	polis, No Location - City o	ID 21403
30	Pages ent of ht: If i		1 ☐ Burial 2 X Cremation 4 ☐ Donation 5 ☐ Other (S)		110	-	natory or other plac 'ematory	θ) 2 <b>–</b> 3–			
Baltimore,	mit. Fortan		21. Signature Funderal Service		140		_		orge P. Kal	lgewater	, MD
ä	Depa tmpo sny ic		Montelle	M		29	73 Solom	ons Islar	nd Rd. Edge	.as ruie Water	MD 21037
***			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that cau	sed the death	n. Do not ente	er the mode of dying	g, such as cardiac	or respiratory arrest,	acci	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition		velia e	^ A	brhytt	Ne one			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequ	uence of):					5 minules
16.	Examiner	_	Sequentially list conditions,	b. Athe	ros	clenos	H'c Caro	lio vas	cylar dis	ease	
./	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequ	Jence of):					
٧	xecul and al-trar	хап	that initiated events resulting in death) Last	c. Due to (or	as a consequ	uence of):					
8760,	or Attending Physician: The law requires that the death certificate be executed that death. Differ death. Differ death. Differ this certificate has been signed by the attending physician and bifector: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	ical E				,					
68	ifficati g phy as the			0.							
Box 6	leath certific attending p	Z/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor	me of pregna	ncy	Ectopic pregnancy			23d. Date of de	alivery
Θ.	a deal	Physiclan/Med	in the past 12 months? 1 ☐ Yes 2 ☑ No		t at time of de		Other (specify)			Month	Day Year
0.	at the de d by the a stached t	Phy	9 Unknown								
Ś	res tha igned b		Part II. Other significant condition					n in Part I.			to the cause of death?
oro	w require been sig should b	eted	Dighetes N			<u>e 1</u>	WO		1 🗆 Yes	2 □ No 3 □ P	robably 4 🗹 Unknown
Records,	has b	Completed by	Hypothyre	pidism_					24a. Was an autopsy	24b. Were a prior to	utopsy findings available completion of cause of
a E	iician: The certificate h rector, page		Demention						performed? 1 ☐ Yes 2 ☑	death?	s 2 No
\frac{2}{5}	siciar certif recto	Be	25. Was case referred to medical examiner?	I I namital:			Othe		h (Check only one)		
ō	Phys ral dis	2	1 ☐ Yes 2 ☑ No  27. Manner of Death	1 Linpa		ER/Outpatient 28b. Time of	3 DOA 28c. Injury	4 Nursing Ho	me 5 Residence		ecify)
on	ding P th. : After I s funera	타	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investig		Day Year)	Injury	Work	? res 2 □ No	20d. Describe now in	dry occurred	
Division of Vital	Attendii rr death. ector: A by the fu	ffca	3 ☐ Suicide 6 ☐ Could n	ined   286. Place of	Injury - At ho	me, farm, stre	et, factory, office		28f. Location (Street a	and Number or F	lura I Route Number,
ā	s afte	Certification:	4  Homicide determi	building,	etc. (Specify	)			City or Town, Sta		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	g Physician: To the be	st of my know	wledge, death	occurred at the tim	e, date and place,	and due to the cause	s) and manner a	s stated.
	the Phin 24 the F	Medical	one)	and manner	o oi examinai	ion and/or invi	estigation, in my op	inion, death occur	red at the time, date a	nd place, and du	e to the cause(s)
	No.	4	29b. Signature and title of certifier	. /	ana	4	29c. License	number 50653		ate signed (Mon.	
,					(					•	206
	2		30. Name and address of person v			23a) (Type, F	rint) GYA	N.C.	SURA eale n	NA.	2717
- š	Sta	e	31. Date filed (Month, Day, Year)		strar's Şignat		V) KOO	ion P	reale 11	1D 0	10757
	Registra		FFB 1 5 20	06 Fam.	. 1	A DOLL					

			For State Registrar	State of Marylar		artment of F			iene g. No. 06	04401
	Physic	ian	1. Decedent's Name (First, Middle, Last)	i . All	F. 17	5		2. Date of Deat Month	h Day Year	3. Time of Death
	/Medi			lie Allen	rull			Februar	y 7 2006	0718 A <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, give s		210		r Location of Death		4c. County of Dea	ath
	Funeral		100 Grayson Avenu			If Under 1 Year	eake City	8. Date of Birth	Cecil	thnlane (State or Foreign
	Director		212-94-1350	M 2□F 26	Yrs.	Months Days	Hours Min.	(Month, Day, SEPT 17.		rthplace (State or Foreign ountry) arvland
	put 🛦		Usual Residence of Decedent  10a. State 10b. County		ty, Town or Lo			10111 1 1/1	17/7	
	ours after death with the Marylan el', or items 23a or 28e-1 show Executiver must be mutilised at	ō								10d. Inside City Limits 1 X Yes 2 □ No
	the A 28e-1	Directo	Maryland Cecil  10e. Street and Number		hesapea	ke City		14/	ng. Citizen of What C	
	3a or	0	100 Grayson Avenu	e Apartment	310	21915				
	deatl	Funeral					lispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No-	United 14. Race - Am	erican Indian,
9	after or ite	F		<ol> <li>Was Decedent Ever in L Armed Forces?</li> <li>1 ☐ Yes 2 M No If Yes, Give</li> </ol>		r Yes, speciny Cuba I□ Yes 2፟ No	an, mexican, Puero Specify:	Hican, etc.)	Black, Whi	te, etc.
8	72 hours after death with the Maryland "naturel", or items 23a or 28e-f show silical Executer Installed at	d by	3 Widowed 4 Divorced	Year or Dates:						hite
15	n 72 "na'	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup kind of work done o	ation during most of work d)	king	l 6b. Kind of Business	/Industry
212	iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5+) 2.		ticultur			Golf Cour	raa
þ	e filec Il Hyg othe	BeC	17. Father's Name (First, Middle, Last)		1101	CICAICUI		ne (First, Middle, M		i se
<u>a</u>	Ments Ments arked	70 6	Leslie L. Fuller				Sherry	Elaine C	line	
Maryland 21215-0036	s 1 and 2 should be filed within if Health and Mental Hygiene. Item 27 is marked other then "other traumatic event, Ite Me.		19a. Informant's Name/Relationship (Typ		19b. Mailin	g Address (Street	and Number or Rui	ral Route Number,	City or Town, State,	Zip Code)
	ss 1 and 2 of Health item 27 i		Angelia V. Fuller		100 G	rayson A	ve., Apt.			City, MD 219
Baltimore,	ides intoff		20a. Method of Disposition 1∑ Burial 2 □ Cremation 3 □Re	emoval from State	cemetery crem	sition (Name of natory or other place TMETNOD:	Febr	uary	loc. Location - City or	
Ħ.	permit, Pa Departmen Importent any injury		' 4 □ Donation 5 □ Other (Specify)	Cer	netery		10,		orth East	, Maryland
Ba	permit. Pages Department of t Importent: If ite any injury or of		21. Signature of Furgeral Service License		Hi	CKS Home	ss of Facility for Fune	rals, P.	Α.	3 2223
			23a. Part1. Enter 1 e disease, or complic shock, or *eart failure. List on y on	ns the caused the deal	h. Do not ente	J W. Stor	ckton Str a. such as cardiac	eet, Elk	ton, Mary	Approximate
	Physician		Immediate Cause (Final	on each line.		1. 1	. 1	or rospitatory and	01,	Interval Between Onset and Death
	/Medical	0 N	disease or condition resulting in death)	Due to (or as a conseq		creati	DS			
	Examiner		Conventinity link conditions	Alcohol	Ab	USP				
	70 E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of).					
V	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	D. A. C.						
8760,	icate be executed physician and s the burial-transit	ai Ei		Due to (or as a conseq	uence or);					
687	ficate phys s the	dicai	d.							
Box (	The law requires that the death certificate has been signed by the attending playage 2 should be detached for use as I	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregna	ancy				23d. Date of de	liven
	death e atte d for	icia	in the past 12 months?	1 Live birth 2 ☐ Feta 4 Pregnant at time of d		Ectopic pregnancy Other (specify)			Month	Day Year
P.O.	that the de ed by the detached	hys	9 🗆 Unknown	9□ Unknown	_					
	uires tha signed d be de	by F	Part II. Other significant conditions cont	ributing to death but not res	ulting in the un	derlying cause give	on in Part I.	23e. Did toba	acco use contribute to	the cause of death?
Records,	w requir been si should	Completed	Dibolar Di	0				1 🗆 Yes	s 2 <b>X</b> No 3 □ Pr	obably 4 Unknown
ec	has b	nple				· · · · · · · · · · · · · · · · · · ·		24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
a F	cate pag							perform 1 Yes 2	ed? death? No 1 ☐ Yes	2 🗆 No
of Vital	Physicien: this certific ral director,	Be	25. Was case referred to medical examiner?	spital:		Otho		h Check onl one		
o	Phys r this ral di	: To	1 ☐ Yes 2 X No  27. Manner of Death	1 ☐ Inpatient 2 ☐	ER/Outpatient 28b. Time of		4 LI Nursing no	me 5 A Resider 28d. Describe hov	nce 6 Other (Spe	cify)
lon	th. : Afte	tior	1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	28c. Injury Work	(? fes 2 □ No	204. 2000/100 1101	· injury cocaring	
Division	i or Attending Physicien: The later death. Director: After this certificate ha lin by the funeral director, page	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At ho	ome, farm, stre				eet and Number or Ru	ural Route Number,
Ö	s afte	Cert	4   Hornicide	building, etc. (Specif	y)			City or Town,	State)	
	To the Hospital or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune		29a. Certifier  (Check only  2 Medicel Examine	cian: To the best of my kno	wledge, death	occurred at the tim	e, date and place.	and due to the cau	use(s) and manner as	stated.
	the H the F the F	Medical		and manner stated.	tion and/or mve	estigation, in my op	oinion, death occurr	ed at the time, dat	e and place, and due	to the cause(s)
	vith Con	2	29b. Signature and title of certifier.	0-1-		29c. License	number	290	d. Date signed (Monta	h, Day, Year)
,			tonen L	aner m	0	D.	1100	0	02/0	8/06
	4		80. Name and address of person who com		, , , , ,	,				
	Sta	te	Karen L. Canter, M. 31. Date filed (Month, Day, Year)	D., 20 Craig B2. Registrar's Signa	town Ko	ad, Suit	e 106, Po	ort Depos	it, Maryla	and 21904
	Registr		FEB 1 5 2006	Rank M	Local	· 8				

			1 - For State Registrar	State of Mary	yland / Depa		lealth and	Mental Hygie	ne 0 6	04402					
	Physic /Medi Examii	cal	1. Decedent's Name (First, Middle, Last,  L S L C  4a. Facility Name (If not institution, give	tree	man,	JR. 4b. City, Town, o	or Location of Deat	2. Date of Death Month	Day Year 25, 2006 4c. County of Deat	3. Time of Death 9 1/30 AM					
	Funeral Director		9311 Caltor Lane 5. Social Security Number 6. Security Number 269-32-2659	Man alle	n yrs. last birthday) 69 Yrs.		Shington   If Under 24 Hrs   Hours   Min.	8. Date of Birth	Prince G 9. Birtl Co. 1936 Oh	George hplace (State or Foreign unity) nio					
9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show any injury or other treumatic event, The Modical Examiner must be maiffied at ance.	Completed by Funeral Director	10a. State 10b. County  Maryland Prince Ge  10e. Street and Number  9311 Caltor Lane	20rge  12. Was Decedent Eve Armed Forces? 1 Xi Yes 2   No	1977 '	shington  10f. Zip Code  2  Was Decedent of H			Citizen of What Consisted Stat  14. Race - Amel Black, White	ncan Indian, e, etc.					
121215-0036	filed within 72 hours Hygiene. other then "natural", ent, the Medical Exa		3 ☐ Widowed 4℃ invorced  15. Decedent's Edu (Specify only highest grade  Elementary/Secondary (0·12)  12  17. Father's Name (First, Middle, Last)		16a. Deced	dent's Usual Occup kind of work done DO NOT use retired f Intell	pation during most of wo d) igence S	rking pecialist		Industry					
Maryland	should be fi and Mental H s marked of umatic ever	To Be	Elisha Freeman,  19a. Informant's Name/Relationship (Ty		19b. Mailír	ng Address (Street	Kati	me (First, Middle, Mai e Kelley ural Route Number, C		(ip Code)					
	Pages 1 and 2 nent of Health a int: If Item 27 Is		Ellis Freeman/Son  20a. Method of Disposition 1	Removal from State		Caltor L	n. Fort	Washington		744					
Baltimore,	permit. Pag Department Important: any injury once.		*4 Donation 5 Other (Specify)  Maryland Veteran Cem. Feb. 2, 2006 Cheltenham, M  21. Signature of Funeral Service Licensee  22. Name and Address of Facility  Pope Funeral Homes 5538 Marlboro Pike Forestville, Md. 20												
	Physician /Medical Examiner		23a. Part1. Enter the duease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Approximate Interval Between Onset and Death  Onset and Death  Due to (or as a consequence of):												
8760,	sate be executed oblysicien and the burial-transit	cai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infittated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):  d.												
O. Box 6	t the death certific by the attending p ached for use as	Physician/Medical	IF FEMALE: 2 20b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	33c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)	1		23d. Date of delin	very Day Year					
ords, P.	w requires that been signed I should be det	by	Part II. Other significant conditions con	ntributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did tobac	co use contribute to	*/					
Vital Records,		e Completed	25. Was case referred to medical					24a. Was an autopsy performed 1 Yes 2 A	prior to condeath?	topsy findings available completion of cause of					
Division of Vi	tending Physeath.	Certification; To Bo	examiner?  1	nvestigation M 1 Yes 2 No											
Dİ	E Sign	edical Certi	29a. Certifier 1 Certifying Phys	building, etc. (S	y knowledge, death	occurred at the tin		City or Town, S	e(s) and manner as	stated.					
)	To the Hospital within 24 hours a To the Funerel I completely filled	Medi	29b. Signature and title of certifier	and manner stated.	·	29c. License	e number	ste 203	Date signed (Month)	, Day, Year)					
<i>f</i> _	(10) [V]	a te	31. Date filed (Month, Day, Year)	impleted cause of death MER MD  32. Registrar's	(Item 23a) (Type, I	Livings	iton Rd	Ste 203;	PT. Wasi	20744 MD					
	Registi		JAN 3 1 2006	Dien 1	Spine.		v								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Ford can JANUARY 23 2006 4:50 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE **UNIVERSITY OF MARYLAND** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JUNE 24 1933 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** Months 1 □ M 2 K F 72 Yrs. WASHINGTON, DC 578-54-4309 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show other traumatic event, the Medical Examiner must be notified at Yes 2 No Funeral Director WASHINGTON.DC 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 3307 12th STREET S.E. 20032 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Completed by BLACK 3 XWidowed 4 ☐ Divorced natural 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) Colfege (1-4or 5+) ADMINISTRATIVE ASSISTANT GOVERNMENT 12th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of should be INEZ LAWS JOSEPH ANDREWS 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 item 27 i 3307 12th STREET S.E. WASHINGTON, DC 20032 ANDREWS/SON NOLAN 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: if ite any injury or of once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) LINCOLN CEMETERY 1/31/2006 BRENTWOOD, MARYLAND 22. Name and Address of Facility J. B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Road Landover, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician disease or condition resulting in death) Sepsis /Medical Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-transit Seizures Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE for use 23c. ff yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🛣 No 5 Other (specify) 4☐Pregnant at time of death P.0 detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown es been signal Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page this certificate 2X No 2**X** No 1 Yes To the Hospital or Attending Physician: "within 24 hours after death." To the Funeral Director: After this certifica 25. Was case referred to medical Be 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 XNatural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) in by t 4 Homicide filled 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P19762 empur 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 22. S. Greene St. Baltimore, MD Ellen Lemkin 31. Date filed (Month, Day, Year) 32. Registrar's Signature been & fort State Registrar JAN 31

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 26, 4:30p <sup>™</sup> 2006 Ferentinos Christos /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital 01nev 8. Date of Birth (Month, Day, Year)
Nov. 2, 1925 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days M 2□F Greece Director <u>577\_56\_5287</u> 80 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Montgomery Olney 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 0 18921 Clover Hill Lane USA or items 23a Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours atter nent of Health and Mental Hygiene. ant: if itam 27 is marked other than "natural; or ite ury or other treumatic event, the Medical Examina 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 → Married Baltimore, Maryland 21215-0036 1 ☐ Yes 3 ☐ No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Owner | Restaurants 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Tsimas Vasilios Ferentinos Georgia 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18921 Clover Hill Lane Olney, Maryland 20832 Metaxas Ferentinos / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages of Department of Hamportant: If Its any injury or ot sace. 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 1/30/06 Silver Spring, Maryland 22. Name and Address of Facility Hines Rinaldi Funeral Home 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave Silver Spring, MD 20904 Ant1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
12 Hours Immediate Cause (Final Intracerebral Bleed **Physician** disease er condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, by 1 Yes 2 No 3 Probably 4 Unknown Completed Hypertension 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an Cerebrovascular Insufficiency autopsy performed? 1 Yes 3€ No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 AInpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA After the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural Injury 5 Pending 1 Tes 2 No investigation Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier January 26, 2006 D0035045 D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 181 Prince Philip Drive #200 Olney, Maryland 20832 Philip G. Henjum, M.D. . Registrar's Signature 31. Date fited (Month, Day, Year) State FEB 0 1 2006 Registrar

			State of Maryland / Dep	partment of Health and I Pertificate of Death	Mental Hygie	Z1111b	04405
	Dhyei	nion	Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physi /Med		RUTH FRANCES FELDMAN		JANUARY 2	5, 2006	18:21 M
	Exam	iner	4a. Facility Name (If not institution, give street and number) Suburban Hospital	4b. City, Town, or Location of Death Bethesda	1	4c. County of Death	
	Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	() If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Montg 9. Birth	omery place (State or Foreign intry)
	Directo		094-22-3130 1□M 2€F 74 Yrs.	Months Days Hours Min.	Month, Day, Ye March 4,	1931 Cou	intry) MA
	р 		Usual Residence of Decedent         10c. City, Town or I           10a. State         10b. County         10c. City, Town or I	ocation			10d. Inside City Limits
	Aaryla f sho	ō	MD MONTGOMERY				1 X Yes 2 No
	the h	Director	10e. Street and Number	SILVER SPRING	10g.	Citizen of What Cou	intry?
	h with	a D	11514 LOVEJOY STREET	20902		U.	S.A.
	eme	Funerai	11. Marital Status 12. Was Decedent Ever in U.S. 13	. Was Decedent of Hispanic Origin? (Si If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Amen Black, White,	
	36 safte	by Fu	1 Never Married 2 Married  1 Never Married 2 Married  3 X Widowed 4 Divorced  1. Ves 2 X No If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	,		HITE
	-00-		15. Decedent's Education 16a, Dec	edent's Usual Occupation	16b	b. Kind of Business/In	ndustry
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,	Maryland 21215-0036 at 2 should be filed within 72 hours after death with the Maryland th and Mental hygiene. Ith and Mental hygiene. 27 is marked other than "naturel", or iteme 23e or 28e-f show treumatic event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last) MYRON BERNSTEIN	SARAH FIS	ne (First, Middle, Maid ЗИМА N	len Sumame)	
,	should Me mark mark	2		ling Address (Street and Number or Ru		tv or Town, State, Zii	p Code)
		1		LOVEJOY STREET, S			20902
	D - 1 5 5/		20a. Method of Disposition  12C Burial 2 ☐ Cremation 3 ⊠Removal from State  20b. Place of Disposition cemetery, cn	osition (Name of ematory or other place)	Date 20c	Location - City or To	own, State
6	Pages Pages ment of h	7	4 □Donation 5 □Other (Specify) KING DAV	ID MEML GDNS 01/2		LLS CHURC	H. VIRGINIA
7	Baltimo permit. Pages Depertment of Important: If I		21. Ignature i uneral some Licentee	22. Name and Address of Facility ANZANSKY-GOLDBERG	MEMORIAL	CHAPELS,	INC.
Se .			23a. Part I. Enter the disease, or complications that caused the death. Do not en	1/0 ROCKVILLE PIKE	E, ROCKVIL	LE, MARÝL	AND 20852
	150		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final				Approximate Interval Between Onset and Death
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	Examine		Sequentially list conditions below STAGE	e rehal di	se sease		
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00	68 tificate of phy as the	Physician/Medical	0.				-
100	Box 6 eath certific attending p for use as	an/M	IF FEMALE:  23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death 3	□Ectopic pregnancy		23d. Date of delive	•
	I Records, P.O. Box 68 The law requires that the death certific ste hes been signed by the attending page 2 should be detached for use as	sici		Dther (specify)		Month	Day Year
/	thet the died by the detached		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tobaco	co use contribute to t	he cause of death?
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3	ecords, law requires t es been signe 2 should be	Completed			24a. Was an	24b. Were auto	opsy findings available
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T.	Sion of Vita tending Physiclen: leath. tor: After this certific the funeral director.	in oil	27. Manner of Death  1 Natural 5 Pending (Month, Day Year) Injury  2 Accident investigation	of 28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how in	ijury occurred	
ie Idman	= 500 >	fica	3 Suicide 6 Could not be 28e Place of Injury - At home farm s		28f. Location (Street	t and Number or Rura	al Route Number,
11	S affer of in the	Certification:	4 Homicide determined building, etc. (Specify)		City or Town, St	ate)	
	DIVI To the Hospitel or At within 24 hours after or To the Funeral Direct completely filled in by	edicai	29a. Certifier  (Check only  Let Medical Examiner: On the basis of examination and/or in	th occurred at the time, date and place,	and due to the cause red at the time, date a	e(s) and manner as s and place, and due t	tated. o the cause(s)
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	6	1	30. Name and address of person who come leted cause of death (Item 23a) (Type	, Print)		.	•
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To the Hospital or At within 24 hours efter of To the Funeral Direct completely filled in by	Medical C		ician: To the best of my knowner: On the basis of examinat and manner stated.							
ai or Attender efter death	Certification:	Accident investigation  3 Suicide 6 Could not be determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre		100 20.00	28f. Location ( City or To		Number or Re	ural Route Number,
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The law ete has by page 2 s	Completed						24a. Was auto perfo 1 — Yes		24b. Were as prior to death?	utopsy findings available completion of cause of 2 No
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that the	Phys	9 ☐ Unknown  Part II. Other significant conditions con	9⊡ Unknown tributing to death but not resu	Iting in the un	derlying cause giv	ren in Part I.	23e. Did 1	tobacco us	e contribute to	the cause of death?
≥ Ou or	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	3c. If yes, outcome of pregnar 1 Live birth 2 Fetal 4 Pregnant at time of de	death 3	Ectopic pregnancy Other (specify)	,		23	d. Date of de	livery Day Year
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Physician /Medical Examiner		In mediate Cause (Final disease or condition resulting in death)	Due to (or as a consequ	ence of):	upral Va	soular	Occide ali	4		8 4001
		23. Part1. Enter the disease, or complic shock, or heart failure. List only on	m0029 cations that caused the death e cause on each line.	. Do not ente	er the mode of dyir	ng, such as cardi		rrest,	nne, M	D 21853 Approximate Interval Between Onset and Death
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permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Heelih and Mental Hygiene. Important: if Item 27 is marked other than "natural; or Items 23s or 28s-f show supingry or other traumatic evant, the MacLeal Examinat must be nutitied at once.		20a. Method of Disposition  1 ☑ Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	emetery, cren	sition <i>(Name of</i> natory or other plac n <b>ily</b> Ceme	· 1	Date / 04/2006		ation - City or	
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Physici	an	Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
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7	Exami	ner	4a. Facility Name (If not institution, give PRINCE GEORGES HO		סיבויויו	41	b. City, Town, o		of Death			Inty of Death		
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936	urs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		10	Yes 2∑No	Specify:			Spe	ecity:BLA	CK	
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Maryland	nd 2 shouth and 27 is mu		TERESA DUBARD/N			_	ddress <i>(Str</i> eet UARLES					wn, State, 21)		
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760,	And it is not in the price of t	cai Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a Due to (or as a Due to (or as a	consequence	of): , ol <sub>j</sub> .	und-	tocv	rest	,			Onset and D	eath
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rds, P	w requires tha been signed I should be det	þ	Part II. Other significant conditions cor	ntributing to death but	not resulting	in the under	rlying cause give	en in Part I.		23e. Did to	50		hecause of de oably 4 ∐Ui	
		Completed										prior to co death?	psy findings a mpletion of ca	vailable iuse of
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n c	ding F h. After funera	<u>ö</u>	27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year)	Time of Injury	28c. Injun Work			8d. Describe h				
Sic	ten for: the	cat	2 Accident investigation 3 Suicide 6 Could not be	127106	2	1:451	9 1	Yes 2 DN	`		sect s			
Division	or A ofter Dire	Certification;	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, to (Specify) 5 Pet	1	tactory, office	_		Bf. Location (S City or Tox Wash	m, State) U	506 QU	al Route Numb	HNE
	Hospital     24 hours     Funeral letely filled	Medical	29a. Certifier (Check only one)  1 Certifying Physical Examination	ner: On the best of	examination ar	e, death oco nd/or investi	curred at the tin igation, in my o	ne, date an pinion, deal	d place, a th occurre	nd due to the	cause(s) and date and plac	manner as s e, and due to	tated. the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	and manner state	90.		29c. License	e number			29d. Date sig	ned (Month,	Day, Year)	
	- 3 - 8		) Causo L	A 1000	(1.1.1)	)	0.C.				ANUARY			
Λ	(2)	-	30. Name and address of person who co	impleted cause of de-	th (Item 23a)	(Type Prin		и. Е.		J	THOUSE !	. 40, 4	2000	
K			CAROL H AT  31. Date filed (Month, Day, Year)	AN J	nd			STRE	ET 1	BALTIMO	RE, MA	RYLANI	21201	-
	Sta Registi		JAN 3 1 2006	Beele	K A	horte	•							

		•	For State Registrar	State o	f Marylar		artment <i>rtificate</i>				ental Hyg	giene Rog. No.	006	04408
2	Physici		1. Decedent's Name (First, Middle, La Dorothy Eliza		oson						2. Date of Dea Month JANUAK	oth Day	6 200 G	
0	/Medio Examir		4a. Facility Name (If not institution, gir Doctors Communi		_		La	nhan				Pr		George's
	Funeral Director	17.	577-24-7770	Sex 1 □ M 2 DXF	7. Age (In yrs. 97	/ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Birth (Month, Pa) 9/16/08	Year)		Birthplace (State or Foreign Country)  LSh., D.C.
	r the Maryland r 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  D.C.		10c. Cit	ty, Town or Lo Wash	ocation ningto	n						10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	death with the	Funeral Director	10e. Street and Number 1701 Benning	Rd.,N.E.	# A-21	I	10f. Zip	Code	2000	2		10g. Citiz	U.S.A	
036	ours after	þ	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Deci Armed Fo 1 Tyes If Yes, Giv Year or D	2⊠No ve		Was Decedi If Yes, spec 1 Yes 2		ispanic Ori n, Mexicar Specify:		ecify Yes or No- Rican, etc.)		Black, W Specify.Af An	rican— merican
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G <sub>1</sub> (SSN) ひはのTHY Baltimore, Maryland 21215-0036	₫ 😇 💆 🗑	To Be Co	17. Father's Name (First, Middle, Las William Bla			100	30. 110		18. Mothe		(First, Middle,	Maiden		
λ. Mary	and 2 should alth and Men 127 is marke er treumatic		19a. Informant's Name/Relationship Katherline E. Ha		ughter						A Route Numbe	yland	2078	35
Cn/BSold,	permit. Pages 1 an Department of Heal Important: if item 2 eny injury or other		20a. Method of Disposition  1X Burial 2 Cremation 3 6 4 Donation 5 Other (Spec		Canada	Place of Disponder of the Place of Disponder of the Place	matory or of Mem.	cem.		2/3/0		Suit	tland,	or Town, State
Balt	permit. Departr Importr eny inj.		21. Signature of Funeral Service Lice 21. Signature of Funeral Service Lice 23a. Part1. Enter the disease, or con-	W. 9.	1 att		1925 B	urro	oughs	Ave.	ons Co., N.E.,	<u>vash</u>	D.C.	20019 Approximate
68760,	Attending Physician: The law requires that the death certificate be executed responsible.  The law requires that the death of the attending physician and a signed by the funeral director, page 2 should be detached for use as the burial-transit	edical Examiner	shock, or heart failure. List onto Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	a Due to b Due to		quence of):	IERS	3	EME	NTI	4.			Interval Between Onset and Death
P.O. Box	at the death certifica by the attending ph stached for use as th	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live t	tcome of pregn birth 2  Feta nant at time of c	al death 3	⊟Ectopic pro					2	3d. Date of Month	delivery Day Year
rds, P.	w requires that is been signed by should be deta	þ	Part II. Other significant conditions	contributing to d		sulting in the u	underlying ca	ause give	en in Part I	l.		obacco u es 20		e to the cause of death?  Probably 4 (1904) own
l Reco	The taw restate has bee page 2 sho	Completed	PERIT	PHERAI	LVA	rscul	AR	Dis	(EAS	SE	24a. Was autop perfor 1 Yes	sy rmed2/	24b. Were prior death	autopsy findings available to completion of cause of ?? 'es 2 \sumbox No
of Vita	Physician: Th this certificate al director, pag	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ №			] <b>F</b> #VOutpatie			er: 4 □ No	ursing Ho	n <i>(Check only o</i> me 5 ☐ Resid	lence 6		pecify)
Division of Vital Records,	i Sir e	Certification:	27. Manner of Death    Natural   5   Pending	on	of Injury  th, Day Year)  of Injury - At h  ing, etc. (Speci	28b. Time of Injury	М		yat k? Yes 2 □		28d. Describe h  28f. Location (S  City or Tow	Street and	d Number or	Rural Route Number,
	To the Hospital within 24 hours a To the Funerei Completely filled	edical C	29a. Certifier (Check only one)  1 Certifying F	Physician: To the aminer: On the band man	e best of my knoosis of examination	owledge, dear ation and/or in	th occurred investigation,	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to the ded at the time, of	cause(s) date and	and manner place, and o	as stated. due to the cause(s)
	To th To th	Me	29b. Signature and title of certifier	auce	3	MO	290		e number	829		29d. Date	i	onth, Day, Year)
CF	(2) Str	ate	30. Name and address of person who SURESHKUWAR 31. Date filed (Month, Day, Year)	MUTT!		203		ENS	BUR	RY R	LD. 14 Y	477	SVILL	E, My 201

			1 - For State Registrar	State of Maryla			t of H	ealth a	nd Mental H		ร็กก	6	04409
			1. Decedent's Name (First, Middle, La						2. Date of I	Death			3. Time of Death
	Physic /Medi		LYDIA	GA	MO				JANUAF	XY 2	8 20	006	2:10 AM
1.80	Exami		4a. Facility Name (If not institution, giv	e street and number)			Town, or	Location of	Death	40	c. County	of Death	1
		(i) (i) (i)	SOUTHERN MARYL	AND HOSPITAL		CL	INTO	N		P	RINC	E GE	ORGE'S
	Funeral Director		020-00-2424	ex	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min. 8. Date of E (Month, I OCTOBI	Birth 1 Day, Year ER 23	925	9. Birthp Cour PHII	elace (State or Foreign etry) LLIPPINES
	and w	}	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
	ith the Marylar or 28a-t show or notified at	Funeral Director	MD PRINCE		CAPITO	L HEI							1 X Yes 2 □ No
	a or	급	10e. Street and Number 6820 JADE COURT			10f. Zip	0743			1	S.A.	Vhat Cour	itry?
	eath w	erai	11. Marital Status	12. Was Decedent Ever in U	19 13 1			onanio Oria	in? (Specific Ven es à				
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other then "natural", or Itema 23s or 28s-t show other traumatic event, the Medical Event artified at	þ	1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	Amed Forces?  1  Yes 2 No If Yes, Give Year or Dates:		f Yes, spec		Specify:	in? (Specify Yes or N Puerto Rican, etc.)	10-	Specify.	k, White,	an Indian, etc. LAN
2-0	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		16a. Deced	dent's Usua	l Occupa	tion	of wordsing	16b. K	(ind of Bu	siness/Inc	dustry
21	within 7 ene. then *r	pje	Elementary/Secondary (0-12)	College (1-4or 5+)				uring most	or working				
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χ	should be nd Mental marked o	2	ALETANDRO BAUTIS					ERF	ANIE BINAE	PE			
Maryland	12 sho h and 7 Is mu trauma	111	19a. Informant's Name/Relationship (						or Rural Route Num				Code) 20743
	1 and Health em 27 ther tr		JULIE ALAM/DAUGH 20a. Method of Disposition		Place of Dispo			I CAP	ITOL HEIG				
Baltimore,	9 5 = 5		1 ☐ Burial 2 🖾 Cremation 3 ☐	Removal from State	cemetery, cren	natory or ot	her place	- 1	2/1/2006			City or To	wn, State RYLAND
Ē			4 □ Donation 5 □ Other (Specification 21. Signature of Fundation Service Licentary)		VERDALE			s of Facility					
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the deal									Approximate Interval Between
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	t f insif	Ę.	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (0. 20 2 00.1000	1001100 01).		0.						
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Box	death certificate be executed e attending physicien and nd for use as the burral-transif	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pre	anancy.				23d. Date	of delive	ry
O. E.	the att	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4☐Pregnant at time of d		Other (spe					Mon	ith	Day Year
P.O.	± 5°°		Part II. Other significant conditions co	ontributing to death but get rec	ultina in the	deat des se			07. 014				
Division of Vital Records,	uires fha signed l d be det	d by	Chamis A	2e h. c/ -1		I IA O	OSE GIVE	iliraili.		Yes 2		,	e cause of death?
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ō	E = E		27. Manger of Death	28a. Date of Injury	28b. Time of		c. Injury	4 LI Nurs	ing Home 5 Res				)
<u>o</u>	Attending Physician: r death. sctor: After this certific: by the funeral director.	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work'	? es 2∐No					
Vis	er der recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre	et, factory,	office		28f. Location	(Street an	d Numbe	r or Rural	Route Number,
۵	Ital or urs afte ral Din led in I									wn, State			
	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After dompletely filled in by the funeral	edical	29a. Certifier (Check only one)  1  Certifying Phyone 2  Medical Example 1	vsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death tion and/or inv	occurred a estigation, i	t the time in my opi	, date and nion, death	place, and due to the occurred at the time	cause(s) , date and	and man d place, ar	ner as sta nd due to	ited. the cause(s)
	To the within 2 To the complet	×	29b. Signature and title of certifier	0	•	29c.	License	number		29d. Dat	e signed	(Month, E	Day, Year)
	(2)		Meh	and Al	tend,	9	D2	402	0	1	128	3/0	6
	Sino		30. Name and address of person who c	ompleted cause of death (Item	23a) (Type, F		^ 4	٥		-	t de	0	-00
	29'(		31. Date filed (Month, Day, Year)	DUL M.D	44	670	ld	Bran	uch Ave	1 8	ams	10 1 10 1	muy
	Sta Registr		JAN 3 1 2006	32. Registrar's Sign	ture						•	1 100	20148

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registres Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 13:08<sub>M</sub> **Physician** February 1 Anna Jean George 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Barton 18600 Takoma Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 7 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F 215-26-6675 75 Director 1930 Maryland Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State item 271 same montain by grown. Item "naturel", or Itams 23a or 28a-f show other treumatic event, the Medical Examiner must be rectified at MD. Allegany Barton 1 ☐ Yes 2 X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21521 18600 Takoma Drive United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, 11. Marital Status Black, White, etc. □Yes 2 No Yes, Give 1 Never Married 2 Married white Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify þ 3X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Is marked other then Elementary/Secondary (0-12) College (1-4or 5+) Housework Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be fi Harry E. Bailey Anna M. Shuhart 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 s ment of Health an permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is eny injury or othar trea once. 22510 Cosgrove Lane, Westernport, Maryland 21562 Melissa Harris/ granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 02/04/ 1XDBurial 2 ☐ Cremation 3 ☐ Removal from State Barton, Maryland Mt. View Cemetery 2006 \*4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boal Funeral Home 1111 Church St., Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclertic heart disease yr S **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year ō Day 4☐Pregnant at time of death 5 ☐ Other (specify) the a detached 9 Unknown à signed I I be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 💘 Z No 3 Probably 4 Unknown page 2 should Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? certificate 1 Yes Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA Other: 4 Nursing Home Residence 6 Other (Specify) Yes 2 □ No Certification: To this 28a. Date of Injury (Month, Day Year) 27. Mapner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funerel Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Hospitel 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D09157 Feb 2 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21502 Maryland Dr. Paul Snow, St., Cumberland, 124 W. 3<sub>2d</sub> 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U U 6 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Month Year 5:42 AM Mary Catherine GRAFF /Medical tebruary 03 2006 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown
If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Washington **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours 1 □ M 2 🔽 F Yrs Director 064-16-7187 April 27 1921 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10b County 10c. City, Town or Location worle 10d. Inside City Limits the Medical Examiner must be notified at Director 28a-f 1 Yes 2X No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or items 23a 205 Benevola Church Road 21713 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes \$77 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ò 1 ☐ Yes 2 ▼ No Specify: 3 YWidowed 4 ☐ Divorced Specify. "natural" White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry d 2 should be filed within 72 h end Mental Hygiene." 7 Is marked other then "na (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Secretary Church 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 John Urban Anna Verostek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 end 2 Department of Heelth er Important: If Itam 27 is eny injury or other tret once. Curtis Graffe - Son 8228 Old National Pike, Boonsboro, Md. 21713
se of Disposition (Name of Date 20c. Location - City or Town, Stat 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 2/2/06 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician s the burial P.O. Box 68760. Be Completed by Physician/Medical nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant atten for u 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the a d be detached for 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 23e. Did tobacco use contribute to the cause of death? RENAL FAILURE 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s autopsy performed Division of Vital 1 Yes 2 No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 (Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Oate of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu 2 Accident investigation 1 Yes 2 No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Machan Hubbly D62562 02-02-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADNAVI HUBBLY WAGHING TON COUNTY HOSPITAL MARYLAND HAGERITUWN 21740 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of	Maryland		artment of H		nd Menta	al Hygie	400	6 04412	)
	<b>D</b> I		1. Decedent's Name (First, Middle, I	Last)						te of Death	Day Ye	3. Time of Death	_
	Physici /Medic		Teresa Girt-Glov	er							30, 200		
	Examin		4a. Facility Name (If not institution, g	ive street and numi	ber)		4b. City, Town, or	Location of I	Death		4c. County of E	Death	
			Holy Cross Hospi				Silver S				Montgor	nery	
	Funeral Director		220-60-3961	.Sex 7 1□M 2X1F	7. Age (In yrs. Ias 50		If Under 1 Year Months Days		Min. (Mo	te of Birth onth, Day, Y	ear)	Birthplace (State or Foreign Country) aryland	1
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits	_
	Mary	ō	Manual and Manual and		Mont	~ ~ m ~ 14:	V:11					1 ☐ Yes 2 X No	
	288 1	Director	Maryland Montgom  10e. Street and Number	ery	Mont	gomer	y Village			100	. Citizen of Wha	t Country?	
	3a or	D	19204 Racine Cou	rt			20886			US		,	
	death with the Maryland ime 23a or 28a-f ehow	Funerai	11. Marital Status	12. Was Deced	lent Ever in U.S.		Was Decedent of H	ispanic Origin	n? (Specify Ye	as or No-	14. Race - /	American Indian,	-
0000	irs after	by Fur	1 ☐ Never Married 2 【XMarried 3 ☐ Widowed 4 ☐ Divorced	Armed Ford  1	<b>X</b> No	1	if Yes, specify Cuba 1 ☐ Yes 2 ☐ <b>X</b> No	n, Mexican, F Specify:	Puerto Rican,	etc.)	0	White, etc. White	
5	2 hou	Completed	15. Decedent's	Education	1		dent's Usual Occup			16	b. Kind of Busin		-
<u> </u>	nin 7.	pie	(Specify only highest of Elementary/Secondary (0-12)	grade completed) College (1-4	40r 5+)	(Give	kind of work done of DO NOT use retired	during most o l)	of working			•	
7	d with	E O	12	Conogo (1-4		Secre	tary			E	ducation	n	
alla	otho Vent	BeC	17. Father's Name (First, Middle, La	st)				18. Mother's	s Name (First,	Middle, Ma	iden Sumame)		
<u> </u>	Menta	To	Wilber Russell B	onifant				Jewe1	Kileen	Byrn	e		
Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Department of Health and Mental Hyglene.  By injury or other treumatic event, the Macilian Examinar matches and the and the and the and the Apple.		19a. Informant's Name/Relationship Robert S. Glover				Racine C						
Ę.	item item		20a. Method of Disposition		COR	ce of Dispo	sition (Name of matory or other place	e)   F	Februar	y 20	c. Location - City	or Town, State	_
altimor	Page nent on int: if		1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		(ate	-	e Cremato		2, 2006	Be.	ltsville	e, Maryland	
Dall	permit. Departr Imports eny inji		21. Signature of Funeral Service Lic	ensee A			Name and Address						
۰			23a. Part1. Enter the disease, or co	mplications that car	MO12 used the death.	Do not ent	everly L. er the mode of dyin	Heckr g, such as ca	rdiac or respi	ratory arrest	Clarksvi	ille, MD 2102	
4	Dhysieise		Immediate Cause (Final	ity one cause on eac	ch line.							Interval Between Onset and Death	
į.	Physician /Medical		disease or condition resulting in death)		atic Lui		ncer						
	Examiner				•	,	e Lung Di	00000					
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	ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c Nicote	ine Add:	ictio	n						
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200	icete be executed physicien and s the burial-transit	dical		d									
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Š	th ce fendii r use	an/h	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnance		Ectopic pregnancy				23d. Date of		
	e dea he et ned fo	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☑ No		nt at time of deat		Other (specify)				Month	Day Year	
	at the	P.	9 Unknown										_
corus,	yeicien: The law requires that the death certificete be executed is certificate has been signed by the ettending physicien and director, page 2 should be deteched for use as the burial-transit	by	Part II. Other significant conditions	contributing to dea	th but not resulti	ng in the ur	nderlying cause give	en in Part I.				te to the cause of death?  Probably 4 □Unknown	
ູ	aw re	plet							24	a. Wasan	24b. Were	autopsy findings available to completion of cause of	
_	The ate he page	Completed							15	autopsy performe Yes 2x	d? deat	h? Yes 2 No	
<u> </u>	ien: rrtifica ctor, I	Bec	25. Was case referred to medical examiner?					26. Place of	f Death Chec	<u>^</u>	110		
>	yeio nis ce dire	2	1 ☐ Yes 2 ☐ <b>X</b> No	Hospital: 1 XInp	oatient 2 🗆 EF	VOutpatien	t 3□ DOA Othe	or: 4 ☐ Nursi	ing Home 5	Residenc	e 6 🗆 Other (5	Specify)	-
5	fter ti		27. Manner of Death 1   Matural 5 □ Pending	28a. Date of (Month,	Injury 21 Day Year)	8b. Time of Injury	28c. Injun Work	at c?	28d. De	scribe how	injury occurred		
2	eath. or: A the fu	cati	2 ☐ Accident investigat					Yes 2∐No					
	after d after d Direct d in by	Certification;	3 ☐ Suicide 6 ☐ Could not determine	288. Place o	f Injury - At hom g, etc. <i>(Specify)</i>	e, farm, str	eet, factory, office			cation (Streety or Town, S		r Rural Route Number,	
	To the Hospital or Attending Physicien: within 24 hours alter death To the Funeral Director: After this certific completely filled in by the funeral director.	Medicai C	29a. Certifier 1 XCertifying 1 (Check only one)	Physician: To the basaniner: On the bas	is of examination	edge, death n and/or inv	n occurred at the time restigation, in my op	ne, date and pointion, death	place, and due occurred at th	e to the caus	e(s) and manne and place, and	r as stated. due to the cause(s)	_
	Vithin Fo the	Me	29b. Signature and title of certifier	wing months			29c. License	number		29d.	Date signed (M	Ionth, Day, Year)	_
+			Bontal	rellan	11 -	M	P D41752			17-1	h m 11 n m 1	2006	
9	2		30. Name and address of person wh	o completed cause	of death (Item 2	3a) (Type,		·		ге	bruary 1	2000	
7			Bergit Schoellma	mn M.D. 1	500 For	est G	len Road	Silver	Sprin	g, MD	20910		
	Sta		31. Date filed (Month, Day, Year)	32. Re	strar's Signatur	.ө							_
	Registr	ar	FEB 0 2	ZUUb	Meser !	5 6	mark p						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 1 teu 24a per ur 852 2-15-06 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death <sup>™</sup>10, 2006 **Physician** February 0259 А м Opal Claudine Haggerty /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Memorial Hospital Havre de Grace Harford 7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Yrs. | Months | Days | Hours | Min. | June | 27 • 1925 5. Social Security Number Birthplace (State or Foreign \_\_Country) 6. Sex **Funeral** 1□M 2 F 217-24-3622 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Maryla Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28e-1 ehow with injury or other treumatic event, If a Medical Examinar must be notified at once. MD Harford Aberdeen 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 650 Law Street 21001 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Bfack, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Maritaf Status 1 Yes 2 XNo ff Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No þ Specify: White 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Secretary U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thompson Maloyed Edith Margaret Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Lee Haggerty (Daughter) 1104 E. Viking Ct. Abingdon, MD 21009 20b. Pface of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R. A. Ferris & Co. 2/11/06 West Chester, PA 21. Signature of Funeral Service Licensee <sup>22</sup> Name and Address of Facility
Tarring—Cargo Funeral Home, P.A.
Aberdeen, Maryland 21001–3399 mai 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock Priysician /Medical Due to (or as a consequence of 7 hours **Examiner** Complete heart block Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner Acute myocardial infarction Attending Physicien: The law requires that the death certificate be executed ed by the attanding physicien and detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Hyperten Sion 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this cartificate has 2∭ No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitaf: 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 28a. Date of fnjury (Month, Day Year) 28c. fnjury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident for Attend aftar death Director: / 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours at To the Funeral D 1 Cartifying Physician: To the bast of my knowledge distribution of the time date and blace and due to the cause(s) and manner se stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certified Medicai and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) February 10,2006 Cus D0063420 30. Name and address of person who completed cause of death (ftem 23a) (Type, Print) 10

DHMH 17 Rev 1/2001

State

Registrar

OUSFAM

Opel M. Haggert

Zubair Siddiq, MD

1 5 2006

32 Registrar's Signature

31. Date filed (Month, Day, Year) FEB 1 5

			For State Registrar	State of M	arylar			ent of H		ind Me	,	giene	nna	04414
	Dhusis		1. Decedent's Name (First, Middle, Las	1)						2	2. Date of Dea			3. Time of Death
	Physici /Media		JULIA HAYN	IE							JÄNUAR	Y 1	7 2006	4:42 P <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give SOUTHERN MARYL						Location of	f Death			County of Dea	
_	Funeral	-	5. Social Security Number 6. Se			. last birthday)	If Un	LINTO der 1 Year	If Under 2	24 Hrs. 8	Date of Birth		RINCE G. 953 9. Bir	thplace (State or Foreign
п	Director		579-72-9347	]M 21K]F	52	Yrs.	Month	s Days	Hours		(Month, Day CTOBER		(4	HINGTON, DC
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Maryl -f eho	ţŏ	MD PRINCE GE	ORGE! S		PITOL 1		PTTC						14 Yes 2 □ No
	th the	Director	10e. Street and Number	OROL D	01.	HIIOH .		Zip Code				10g. Citi:	zen of What Co	ountry?
	ours after death with the Maryland et', or itame 23a or 28e-f ehow Examinar itausi be notified at		6856 WALKER MILL	ROAD APT	101		1	20743				U.S	.A.	
		Funeral	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent	?		Vas De f Yes, s	cedent of Hi pecify Cuba	ispanic Orig In, Mexican,	gin? (Speci , Puerto Ri	fy Yes or No- can, etc.)	1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
99	hours after turel, or ita	Þ	3 Widowed 4 Divorced	1 ☐ Yes 2 亿 If Yes, Give Year or Dates:	NO	1	Yes	2 No	Specify:				Specify:	BLACK
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[2	filed within 72 Hygiene. other than "neight, the Medic	mpi	Elementary/Secondary (0-12)	Cotlege (1-4or	5+)	life. L	00 NO1	use retired	)	or working		0	OUTDANK	יאיתי
7	e filed value of the r	ပိ	12th 17. Father's Name (First, Middle, Last)			TEA	CHE	R AIDI		r's Name (i	First, Middle,		OVERNME Sumame)	INT
<u>a</u>	d bear	To Be	JESSIE M. HAYNIE								SMITH			
Maryland 21215-0036	id 2 should th and Men 27 ie marka traumatic	-	19a. Informant's Name/Relationship (T										Town, State, 2	Zip Code)
	s 1 and 3 lifem 27 other tre		NILES THADDEUS HA	YNIE/BROT		5500 Place of Dispos			AD CL	_	, MARY			
Baltimore,	0 0		1 Burial 2 □ Cremation 3 □I			cemetery, cren ESURREC	natory o	r other plac		Dat			oation - City or NTON , MA	
<u>=</u>	permit. Peg Depertment Importent: i any injury o		Donation 5 ☐ Other (Specify,  21. Signature of Fun, al Service License		- KI				s of Facility				FUNERA	
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			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that cause ne cause on each l	d the dea ine.	th. Do not ente	er the m	ode of dying	g, such as c	cardiac or r	espiratory arr	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a/	Ne	lastu	tr	z U	Terra	ue (		ca	7	Onset and Death
	Examiner		ſ	Due to (or as	a consec	quence of):							'	
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8/60,	the death certificate be executed y the ettending physicien and sched for use as the buriat-transit		rosuming in coam) case	Due to (or as	a consec	quence of):								
289	ficate physics the	edicai		d			-							
XOR	leath certific ettending p	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			· : -					2	3d. Date of deli	ivery
	e deat	hysician/M	in the past 12 months? 1 \( \text{Yes} \) 2 \( \text{DNO} \)	1 ☐Live birth 4 ☐ Pregnant a 9 ☐ Unknown				pregnancy (specify)					Month	Day Year
J O	that the dended by the educed is	<b>Q</b> .	9 ☐ Unknown  Part II. Other significant conditions co		out not res	culting in the up	darhiine		o in Cart I		22a Did tol	haasa u	a contributo to	the cause of death?
Hecords,	<b>6</b> 5 6	ρ	Tarris sugar significant conductions co	minouting to death t	or nor res	saming in the un	ict <del>o</del> n iyin iç	I cause give	min rani.			es 2		
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VII	ysician: The is is certificate ha director, page ?	Be (	25. Was case referred to medical examiner?	,						of Death (	Check only on			-
6	this ald	<u>1</u>	1 Yes 2 No	dospital:		ER/Outpatient	3 🗆 1		4 🗀 14013				Other (Spec	cify)
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UIVISION	Attendi er death. rector: A by the fu	Certification;	3 Suicide 6 Could not be	28e. Place of In	jury - At h	ome, farm, stre	et, fact	ory, office		28f			Number or Ru	ral Route Number,
5	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fr										City or Towr			<u> </u>
	Hoss 24 hoi Fune Hely fin	Medical	29a. Certifier 1 Certifying Phy (Check of hy one) 2 Medical Exami	sician: To the best ner: On the basis of and manner st	it examina	owledge, death ation and/or inv	occurre estigation	d at the tim on, in my op	e, date and pinion, death	place, and n occurred	d due to the ca at the time, d	ause(s) a ate and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of entier	wind maillier St	wied.		2	9c. License	number		2	9d. Date	signed (Monti	n, Day, Year)
			JE M	1			(	504	54	r		Ja	~ any	27,06
	(0)	3	30. Name and address of person who co										r	
	- JUC	10	ARASTOO YAZDANI 31. Date filed (Month, Day, Year)	M.D. 98		EORGIA	AVE	NUE #	41 SI	LLVER	SPRING	G,MA	RYLAND	20902
	Sta Registr		JAN 3 1 2006	_		ature								

			partment of Health and Mental ertificate of Death	Hygiene 006 04415
0		Decedent's Name (First, Middle, Last)	2. Date (	of Death 3. Time of Death
Physic /Med		Paul Ernest Henderson	Janu	
Exam		4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		1700 Peachtree Lane	Bowie	Prince Georges
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	Months   Days   Hours   Min.   (Monti	h, Day, Year) Country)
Directo	r	578-54-7921   XM 2   64 Yrs.	Aug.	23,1941 Wash.,DC
yland		10a. State 10b. County 10c. City, Town or L	ocation	10d. Inside City Limits
Mar a-fsh	to	MD PG Bowie		Y Yes 2 □ No
th the or 28	Funeral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a	ia I	1700 Peachtree Lane	20721	United States
er de	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. Was Decedent of Hispanic Origin? (Specify Yes of If Yes, specify Cuban, Mexican, Puerto Rican, etc.	or No- 14. Race - American Indian, Black, White, etc.
illed within 72 hours after death with the Maryland Hygiene. Hygiene and a start of items 23a or 28a-f show ent, it of Maryles I Start or Items 23a or 28a-f show ent, it of Maryles I Start or items 23a or 28a-f show	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 ☐ Yes 2 ☐ No Specify:	Specify:
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nin 72	pie	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of working DO NOT use retired)	
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al Hy d oth	Be (	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Ma	iddle, Maiden Sumame)
a y a to L. C. Should be filed within and Mental Hygiene. is marked other than aumatic event, ir e. M.	10	Leroy G. Henderson	Augustine	
s 1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-1 shouther traumatic event, in a Marylical Examiner count be natified at			ling Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
C, IV		Colleen Henderson/wife	O Peachtree Lancary Mary Land Date	20c. Location - City or Town, State
permit. Pages 1 and 5 Department of Health Important: If item 27 any Injury or other tr		1 Surial 2 ☐ Cremation 3 ☐ Removal from State cemetery, cre	ematory or other place)	
it. Parturant			ncoln Cem. 11/27/06 22. Name and Address of Facility Hodge	Brentwood, Md.
Department of the popular of the pop				s & Edwards F.H. , Suitland, Md. 20745
0.10411		23a. Ptv1. Enter the disease, or complications that caused the death. Do not en		orv arrest. Approximate
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Do - O Diasa	Interval Between Onset and Death
/Medica		disease or condition resulting in death)	wind from	20
Examine	1	lyse II	mahetis Mellit	~
P #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		
ocuted nd transi	Examiner	that initiated events c.	sin	
be executed ician and burial-transit		resulting in death) Last Due to (or (s)a consequence of):		
cate be executed physician and the burial-transit	Physician/Medical	d		
The law requires that the death certificate are has been signed by the attending physpage 2 should be detached for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy	<del>-</del>	COL Date of delices
atten for u	cian	in the past 12 months?	☐Ectopic pregnancy ☐ Other (specify)	23d. Date of delivery  Month Day Year
the d	iysi	1 Yes 2 No 9 Unknown 9 Unknown		
s that	by PI	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e.	Did tobacco use contribute to the cause of death?
quires quires on sign	ed b	Cornary artery dise	asl	1 Yes 2 No 3 Probably 4 Munknown
aw re	plet	9		Was an 24b. Were autopsy findings available
The I	Completed		1 D Y	autopsy performed? performed? death?  /es 2 ▼ No 1 □ Yes 2 ▼ No
vical necessician: The law secondificate has builtedor, page 2 s	BeC	25. Was case referred to medical examiner?	26. Place of Death (Check of	- 11 - 11
Physic Physic this ce al dire	10	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatie		Residence 6 Other (Specify)
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or At after of Direction by	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)		ion (Street and Number or Rural Route Number, r Town, State)
To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place, and due to	the cause(s) and manner as stated
24 h 24 h e Fur letely	edical	(Check only 2 Medicel Exeminer: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occurred at the t	ime, date and place, and due to the cause(s)
To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		Maul In Walson	0 041276	1126/06
(6)		30. Name and address of person who completed cause of death (Item 23a) (Type	Print) PI	11 010 12 2111
		31. Date filed (Month, Day, Year) 22. Registrar's Signature	utulace Syl	Hand Mado) 46
∞ S Regis	itate strar	JAN 3 0 2006	A.	
DUMH 17 Pay 1		The same of the sa		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 04416 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Yvonne Loretta January 26, 2006 Hall 1420 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Community Hospital Prince Georges Cheverly 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 1 □ M 2 🖺 F 579-58-4226 66 May 14, 1939 Washington, D.C. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Prince Georges Maryland Glenarden 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7922 Piedmont Ave. 20706 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 11. Marital Status Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Disabled N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James I. Hall Flossie Hammond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah A. Hall / Daughter 1623 Holbrook St. N.E. #3 Washington, D.C. 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Olivet CemeteryFeb. 4,2006 Washington, D.C. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligarisee 22. Name and Address of Facility Alexander S. Pope Funeral Homes 5538 Mariboro Pike/Forestville, 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20747 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Arter oronary Due to (or as a consequence of): Hy PERTENSOF

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown ABETES FUI TUS 1 ☐ Yes 2 X No 24b. Were autopsy findings available prior to completion of cause of death? BILATERAL 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 NO R/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Examiner ettending physicien and for use as the burial-transit To the Hospitel or Attending Physicien: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, sete has been signed by the e page 2 should be detached f After the

within 24 hours a To the Funerel C

Physician

/Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Certification: To

Medical

**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other then "natural", or items 23a or 28a-f entrany injury or other treumatic event, the Mention III any injury or other treumatic event, the Mentions III and II

LINDA 31. Date filed (Month, Day, Year) State

(Check only one)

29b. Signature and title of certifie

FEB 0 1 2006

uen) ms 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREEN D MD

3001 HOSPITAL DRIVE . Registrar's Signature

Registrar

29c. License number

D21428

29d. Date signed (Month, Day, Year)

HEVERLY

		For State Registrar	State of Maryla	nd / Depa		ealth and M	lental Hygi	ene g. No 006	04417
		Decedent's Name (First, Middle, Las.	1)				2. Date of Death		3. Time of Death
Physici		Jo-Anne Sewell	Hunter				January	27 2006	
/Medic Examin		4a. Facility Name (If not institution, give			4b. City, Town, or	Location of Death	J- 011-012-J	4c. County of Dea	
		14816 Fireside	Drive		Silve	er Spring	2	Montg	omery
Funeral		5. Social Security Number 6. Se	7. Age (In yrs	. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		rthplace (State or Foreign Country)
Director		Usual Residence of Decedent	□M 2 <b>X</b> ) F 62			riours iviiii.	Apr. 27,	1943 Per	nsylvania
daryla f shov	٥	10a. State 10b. County		ity, Town or Lo					10d. Inside City Limits 1 X Yes 2 No
r 28e-	Director	Maryland Montg  10e. Street and Number	omery		10f. Zip Code	lver Spri		g. Citizen of What C	Country?
th wit	a D	14816 Fireside	Drive			20905		United	States
dea	Funeral	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of His f Yes, specify Cubar	spanic Origin? (Sp	ecify Yes or No-	14. Race - Am	erican Indian,
s 1 and 2 should be filed within 72 hours after death with the Maryland f Healith and Menhall Hygiene. After the mass 23a or 28e-f show other treumstic event, It we Medical Execution in all the actions and the mailting a	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ॡ Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 【XNO	Specify:	riidari, etc.)	Black, Wh	Black
72 hours af "naturel; or	ompieted	15. Decedent's Edi (Specify only highest grad	ucation de completed)	(Give	lent's Usual Occupa kind of work done d	uring most of work	ing 1	6b. Kind of Busines:	s/Industry
d within giene. ar then	dmo	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use retired)			0	
filed Hygi other	Ö	17. Father's Name (First, Middle, Last)			Higher E		e (First, Middle, M		rnment
should be fit nd Mental Hy marked oth umatic even	OB	John Sewel	1					Murray	
shou nd M mar	1	19a. Informant's Name/Relationship (T		19b. Mailir	ng Address (Street a	nd Number or Run		City or Town, State,	Zip Code)
and 2 shealth and n 27 is n		LaHugh Bankston	/Companion					ring, MD	
s 1 a of Hei	3	20a. Method of Disposition		Place of Dispo	sition (Name of natory or other place		Date 2	Oc. Location - City o	r Town, State
permit. Pages 1 an Department of Heal Importent: If item 2 eny injury or other once.		1 Surial 2 Cremation 3 :	Removal from State		oln Cemet	'	2006	Brentwo	od MD
mit. partm porte y inju		21. Signature of Funeral Service Licens			. Name and Address			neral Hon	
Depa Impo eny ii		John T. D	Tewart III		4001 Ber	nning Rd.	, N.E. V	lash., DC	20019
Massissa		23a. Part 1. Enter the disease, or comp shick, or heart failure. List only of Immediate Cause (Final	one cause on each line.		er the mode of dying	, such as cardiac	or respiratory arres	st,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Hepatic fa						3 weeks
Examiner		Sequentially list conditions	b. Hepatic mo	etastas	es				16 months
sit ad	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse						
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the de	nysic	1 □ Yes 2 🕅 No 9 □ Unknown	4☐Pregnant at time of 9☐ Unknown	death 5	Other (specify)				
The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	by	Part II. Dther significant conditions co	ontributing to death but not re	sulting in the u	ndertying cause give	n in Part I.	000	v	to the cause of death?
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icien: 'ertifica'ector, p	Be	25. Was case referred to medical examiner?	Hospital:		0		h (Check only one		
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ing I. Afte fune	ertification:	27. Manner of Death  1X Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work	at ? ′es 2 □ No	28d. Describe hov	vinjury occurred	
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To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifica completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	vsician: To the best of my kn iner: On the basis of examin and manner stated.	owledge, death ation and/or in	occurred at the time vestigation, in my op	e, date and place, inion, death occurr	and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
To the within To the comple	Me	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)
			5Cen _	_	128	<u> ১</u> তি।		1/31/200	t .
(10)		30. Name and address of persol who c			Print)		#A		
		James D. Alhlgr			y⊥vania A	ve., N.W.	., #3-428	, Wash.,	DC 20037
Sta Registr		31. Date filed (Month, Day, Year)  FEB 1 2006	I. Registrar's Sign	Land	E.				

DHMH 17 Rev 1/2001

Registrar

		1 - For State Registrar	State of Maryla			nt of H te of L		ind Me		giene	UUb	044	19
Physicia	n	Decedent's Name (First, Middle, Las	t)						<ol><li>Date of Dea Month</li></ol>	ath Day	/ Year	3. Time of	Death
/Medica	ai .	KERMIT CHRISTOPHE				Ţ			JANUARY 2			11:10	A M
Examine	er	4a. Facility Name (If not institution, give	street and number)				Location of	r Death			County of Deat	tn	
Funeral		738 SONATA WAY  5. Social Security Number 6. Securi	ax 7. Age (In yr.	s. last birthday)	If Unde	ER SPR or 1 Year	If Under 2		8. Date of Birt	h	NTGOMERY 9. Bird	thplace (State of	or Foreign
Director		577-84-7325	ÄM 2□F 4	2 Yrs.	Months	Days	Hours	Min.	Month, Da, APRIL 3,			intry) IGAN	
pu >		Usual Residence of Decedent  10a, State 10b, County	100 (	City, Town or Lo	antine.							10d. Inside C	Sau I Saulan
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death with the Maryland me 23a or 28e-f show	Director	MARYLAND MONTGOMERS  10e. Street and Number	Z SIL	VER SPRIN		p Code	_			10a Citi	izen of What Co	ountry?	
With With	<u></u>	738 SONATA WAY				20901				-	S.A.	ournay.	
me 2	Funeral	11. Marital Status	12. Was Decedent Ever in	U.S. 13.			spanic Orig	gin? (Spec	cify Yes or No Rican, etc.)		14. Race - Ame		
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apartment of Health and Ments portant: If Item 27 is marked by Injury or other treumatic e-	၉	JAMES CERMIT I	HOUSTON	10b Madi	na Addra	on / Stront	BERNI		Pouto Numbe		HNSON or Town, State,	Zin Codel	
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Heall Sher	ļ	KAREN GRAY HOUSTON/WII  20a. Method of Disposition		Place of Dispe	sition (Na	ame of			G, MARYL <i>l</i> ate		0901 ocation - City or	Town, State	
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important: eny injury o	i	21. Signature of Funeral Service Licen		TE OF HE.	2. Name a	and Addres	s of Facility	02/02/ y		SILVE	ER SPRING	MARYLAN	ND
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attending p	/Me	IF FEMALE:	23c. If yes, outcome of pred	nancy							23d. Date of de	livery	
d for L	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		□Ectopic   □ Other (:	pregnancy specify)					Month	•	Year
teched	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unknown			.,							
	by PI	Part II. Other significant conditions of	ontributing to death but not r	esulting in the t	underlying	cause givi	en in Part I.		23e. Did t	obacco i	use contribute t	o the cause of	death?
									10	Yes 2	□No 3□P	robably 4 🖔	Unknown
2 shoul	Completed								24a. Was		24b. Were a	utopsy findings	available
page 2	E								perfo	rmed? 2 □ No	death?	completion of o	cause of
	Bec	25. Was case referred to medical examiner?				-	26. Place	of Death	Check only		1		
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ter t		27. Manner of Death 1 ÄNatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	of	28c. Injun Work	y at k?		8d. Describe				
	cati	2 Accident investigation 3 Suicide 6 Could not b			M	1 🗆	Yes 2 ☐1	No					
in b	Certification:	4 Homicide determined	28e. Place of Injury - Albuilding, etc. (Spe		reet, facto	ry, office		2	28f. Location ( City or To	Street ar wn, State	nd Number or R a)	lural Route Nur	nber,
To the Funeral Completely filled	edical Ce	29a Certifier 1 Z Certifying Fh	ystrian. To the best of my a niner: On the basis of exam	newladge, dec	ifi occurra	d at the tin	ne dat. an	id place, a	and dua to the	cause(s)	) and marrial a	e stated	(s)
the I	Medi	one)  29b. Signature and title of certifier	and manner stated.	M		9c. Licens							
. 1	_	250. Signature and this of certifier								∠Ju. Da	ite signed (Mon	, vay, rear)	
)		· · · · · · · · · · · · · · · · · · ·			-	D00332	293			JANU	JARY 30,	2006	
		30. Name and address of person who				O1117***	, O114.05	3 141 -	VI 4315 ^^	015			
Sta	to	FREDERICK SMITH, M.D. 31. Date filed (Month, Day, Year)					CHASE	L, MAR	ILAND 20	8T2			
Registr			32 Registrar's Sig	JA A	real								

		•	For State Registrar	Otate of Me	arytaria /		tificate of	Death	viorital 119	Reg. N		0 4 4 2 0
Phy	sicia	n	1. Decedent's Name (First, Middle, La John Early Heane	•			-		2. Date of De Month	eath Ç	29, 20 <sup>0</sup> 6	3. Time of Death
/M	edic	al	4a. Facility Name (If not institution, give				4h Cily Town o	r Location of Death		_	Ic. County of Deat	2:00 рм
Exa	imine	er	419 Christopher		13		Gaither				Montgo	
Fune Direc			,	6ex 7. Age 1	78	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Oct. I	nth ay, Yea	Q Rie	hplace (State or Foreign untry) 1essee
and		}	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	wn or Lo	cation					10d. Inside City Limits
Mary I-f ⊕h¢		ğ	Maryland Montgo	omery	Gaith	erst	ourg					1 □ Yes 2 ☐ No
with the		Il Director	10e. Street and Number 419 Christopher	Avenue, Ap	ot. #T3		10f. Zip Code 20877			10g. (	Citizen of What Co	untry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.		by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ♣ Divorced	12. Was Decedent I Armed Forces? 1 图 Yes 2 □ N If Yes, Give Year or Dates:		51-	Was Decedent of H f Yes, specify Cuba 1 ☐ Yes 2X No	dispanic Origin? (S an, Mexican, Puent Specify:	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, Whit Specify: Whi	e, etc.
72 ho		Completed	15. Decedent's E (Specify only highest gr		16	a. Deced	ient's Usual Occup	pation during most of wor d)	kıng	16b.	Kind of Business/	Industry
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uld be Menta		9 P	Charles Heaney					Lula	Kyle			
2 sho and I			19a. Informant's Name/Relationship	Type, Print)	15	b. Mailir	ng Address (Street	and Number or Ru	ral Route Numb	ber, City	or Town, State, 2	Zip Code)
Pages 1 and 2 nent of Health a			Michael E. Heaney 20a. Method of Disposition	/ son	20b Place	0708	Bucknel sition (Name of	l Drive,	Silver		Location - City or	
ages ont of it: If It	(A)		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		cemet	ery, cren	natory or other place n Cremators		ary 31			Virginia
permit. P Departme Importan	puce.		21. Signature of Funeral Service Lice		- Lacopa	F <sup>22</sup>	Name and Addre	sscotficians	Funera	l Ho	ome Inc	, MD 20901
V. J. T.		$\dashv$	23a. Part1. Enter the disease, or com	nplications that caused	the death. Do						r spring	Approximate Interval Between
Physici	an		shock, or heart failure. List only Immediate Cause (Final	one cause on each lin	10.				. ,			Onset and Death
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w require been sig			Hypertension						1 🗆	Yes	MO 3□Pr	obably 4 Unknown
The law rate has be	page 4 st	Completed								opsy ormed?	prior to death?	itopsy findings available completion of cause of
olcien: The certificate	acioi.	Be	25. Was case referred to medical examiner?	Hannial.				26. Place of Dea				
Phys.	5	၉	1 Yes 28 No 27. Manner of Death	Hospital: 1 Inpatie		Dutpatien	JU DON		ome 5 Res		6 ☐Other (Spe	cify)
tranding Physicien: Jeath. Tor: After this certific		Certification:	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injur (Month, Day	(Year)	Injury	Wor	rk? Yes 2 □ No	200. 0000.00	11047 111	jury occurred	
r Atts	5	t t	3 Suicide 6 Could not be determined	28e. Place of Inju-	ry - At home,	farm, str	eet, factory, office		28f. Location City or To			ural Route Number,
ral Di	200											
To the Hospital or Attendi Within 24 hours after death. To the Funeral Director: A	completely miso in by	edical	29a. Certifier 1 ☐ Certifying Pl (Check only one) 2 ☐ Medical Exa	hysician: To the best of miner: On the basis of and manner sta	examination a	ge, death and/or in	n occurred at the tile vestigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	cause , date a	(s) and manner as and place, and due	s stated. to the cause(s)
104		Σ	29b. Signature and title of certifier	M. Weis	, MD	>	29c. Licens				Date signed (Mont anuary 3	
			30. Name and address of person who Lowell M. Weiss,	M.D. 730	24th 5	Stree	et, NW, #	7, Washi	ngton,	DC 2	20037	
Reg	Sta gistra	-	31. Date filed (Month, Day, Year) FEB 0 1 2	006 32 Registra	ar's Signature	Age	well					

DHMH 17 Rev 1/2001

Be Completed by Physician/Medical Examine ed by the attending physician end datached for usa as the burial-transit Attending Physician: The law requiras that tha deeth certificate be exacuted Division of Vital Records, P.O. Box 68760, Medical Certification: To To the Hospital or Attending Physimithin 24 hours after deeth.

To the Funeral Director: After this completaly filled in by the funeral di

**Physician** 

/Medical

Examiner

**Funeral** 

Director

item 27 is marked other than "naturel", or items 23s or 28s-f show other traumetic event, the Medical Examiner mast be notified at

Peges 1 and 2 should be filed within 72 hours after deeth with in ant of Health and Mental Hygiene.
Int: If Item 27 is marked other than "naturel, or Items 23a or

parmit. Peges 1 and 2. Department of Health a Important: if item 27 is eny Injury or other tratonce.

**Physician** 

/Medical Examiner

Baltimore, Maryland 21215-0020

Completed by Funeral Director

d.					
Part II. Other significant conditions cont	ributing to death but not res	_	g cause given in Part I.	23b. Did tobacco use co	ontribute to the cause of death
Aortie	stanosi	5		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner?	ospital: 1 Inpatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ot	her (Specify)
27. Menner of Death  1	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occu	rred
3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - At h building, etc. (Speci		tory, office	28f. Location (Street and Num City or Town, State)	ber or Rurel Route Number,
				ce, and due to the cause(s) end mourred at the time, date and place	
29b. Signature and title of certifier			29c. License number	29d. Date sign	ed (Month, Day, Year)
X > Faind me	May		0060396	02/0	106
30. Neme and address of person who con	npleted cause of death (Ite	m 23a) (Type, Print)	1126 OP	al ct	017/10

State

FARID 31. Date filed (Month, Day, Year) FEB 02

32. Régistrar's Signature

MURSHED

opal MD Hayarstown

21740

Registrar

			State of Manua		tment of Health and M	•	_	01100
			1 - State Registrar		ficate of Death	Reg. N	2000	04422
	Dhuaisi	0.0	Decedent's Name (First, Middle, Last)	11 .		2. Date of Death Month	Day Year	3. Time of Death
1	Physici /Medio		Annabelle	HARRIS		1 2	9 2006	1255 M
1	Examin	ier	4a. Facility Name (If not institution, give street and number)	4	lb. City, Town, or Location of Death	4	4c. County of Death	
-	Funeral		Feninsula legional medical (e) 5. Social Security Number 6. Sex 7. Age (In yr		If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Yea	Wiconia 9. Birthpla	ace (State or Foreign
	Director		219-14-3867 10M 2×F	83 Yrs. 1	Months Days Hours Min.	09-29-19	122 Countr	"MD
	and w		Usual Residence of Decedent         10a. State         10b. County         10c. 0	City, Town or_Locat	tion		100	d. Inside City Limits
	Maryi -f aho	tor	MD SOMERSET (	Cris fi	eld			1 2 Xes 2 □ No
	th the	Director	10e. Street and Number		10f. Zip Code	10g. (	Citizen of What Countr	y?
	72 hours after death with the Maryland natural', or itema 23a or 28a-f ahow dical Exantior must be codified at	rai	201 HAIL Highway		21817		U.S.A	
	item	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ▼ No	U.S. 13. Wa	s Decedent of Hispanic Origin? (Spi es, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, et	
036	ini', or	þ	3 X Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 🗆	Yes 2⊠ No Specity:		Specify: 13/0	icki
21215-0036	be filed within 72 hours after death with the Marylan hal Hygiene. Id other than "natural", or itema 23a or 28a-f ahow avant, it a Midical Examinar must be collised at	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give kin	nt's Usual Occupation and of work done during most of work	n <i>g</i>	Kind of Business/Indu	1
121	within ene. than	duic	Elementary/Secondary (0-12) College (1-4or 5+)		om Estic	P	rivate Fan	nily Home
<b>b</b>	be filed tal Hygi d other	BeC	17. Father's Name (First, Middle, Last)			(First, Middle, Maid		
ylar	should be nd Mental marked o	ToE	John Hickman		JENN:		ckman	
Maryland	s 1 end 2 should f Heelth and Mer itam 27 is marke other traumatic	1	Jeaneth Stelling Relationship (Type, Print)		Address (Street and Number or Rura	al Route Number, City a Himore,	v or Town, State, Zip C UD 212	_
	s 1 en f Heeli itam 2 other		20a. Method of Disposition 20b	p. Place of Disposition Cernetery, cremat	ochran AVE B		Location - City or Tow	
E O	Pages nent of int: if it iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	T Per 11	.N.C Cemely 02-0	4-2006 1	Marion, W	D
Baltimore,	permit. Pages Depertment of Important: If I any Injury or once.		21. Signature of Funeral Service Licensee	22. N	Jame and Address of Facility  Hony & Ward  14 Cove ST	Funeral H		
	<b>0</b> □ = 0		23a. Part 1. Enter the disease, or complications that caused me de					Approximate
	Pnysician	. 11	shock, or heart failure. List only one cause on each le. Immediate Cause (Final	L CONTROL SITUATION	1/12 B B A A A	atory a est,	/ - 1	interval Between Onset and Death
4	/Medical		disease or condition resulting in death)  Due to (or as a consi	equency of):	vy viennera	My	nami	
	Examiner	er	Sequentially list conditions, b.	17-				
	nted Insit	mine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Character in furty that initiated events c.	eduence or):		-		
o,	ite be executed sysicien and ne burial-transit	Examin	resulting in death) Last	equence of):				
8760,	ate be hysicii the bu	licai	d.					
89 x	death certificate k ie ettending physic od for use as the b	/Mec	IF FEMALE: 23c. If yes, outcome of preg	onancy				
Вох	d for u	cian	23b. Was decedent pregnant in the past 12 months?  1	etal death 3 Ec	ctopic pregnancy ther (specify)		23d. Date of delivery Month D	∕ Day Year
<u>о</u> .	res that the de signed by the e be detached t	Physician/Medi	9 Unknown					
-	requires thet the	þ	Part II. Other significant conditions contributing to death but not re	esulting in the unde	erlying cause given in Part I.		o use contribute to the	
Š		Completed	1 dan 1				2 No 3 Probat	
Rec	9 ia 19 2	дшс	OLD DICA			24a. Was an autopsy performed?	prior to comp death?	sy findings available pletion of cause of
of Vital Records	ician: Th certificete rector, pag	0	25. Was case referred to medical		26. Place of Death	1 Yes 2 H	1  1	□ No
× √	Physician: this certific ral director,	To B		☐ ER/Outpatient		me 5 Residence	6 □Other (Specify)	
u C	ding P	ion:	27. Manner of Death 28a. Date of Injury 1 ☐ Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	Work?	28d. Describe how in	jury occurred	
Division	al or Attanding Physis setter death. In Director: After this ced in by the funeral dire	fical	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At	t home, farm, street	M 1 Yes 2 No	28f. Location (Street	and Number or Rural I	Route Number,
á	s efter at Dira	Certification:	4 Homicide determined building, etc. (Special	cify)		City or Town, Sta	16)	
	To the Hospital or Atta within 24 hours effer de To the Funeral Directo completely filled in by th	edicai	29a. Certifier 1 Certifying Physici n: To the best x my ki	nowledge, death or investination and/or inves	ccurred at the time, date and place, stigation, in my opinion, death occurr	and due to the cause ed at the time, date a	(s) and manner as stated	ed. he cause(s)
	To the within 2 To the comple	Mec	29b. Signatuye/and title of certifier		29c. License number		Date signed (Month, Da	
	,- 0		NIX ) MINAN A	Valud.	Afth ()-J-	56//	1-30-2004	
			20 Name and address of person who complete cause of death (It	tem 23a) (Type, Pri	et millhin	MA		
	Sta	te	KALI KUMN, M.D. 1340 5. 7  31. Date filed (Month, Day, Year) 32. Registrar's Sig		or. sporsony			
-%.	Registr			u K	South .			

	-	For State Registrar	ate of Maryland		irtment of H tificate of I			ene 006	04423
		Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
Physicia		Metha Johnson Hasti	ngs				Month	Day Year	0630 M
/Medic Examin		4a. Facility Name (If not institution, give street			4b. City, Town, or	Location of Death		4c. County of Dea	
LXamii		Peninsula Deninal me	disal Center	-	Salis	Lury		Wicon	nico
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
Director		221-12-7238 <sup>1□ M 2</sup>	84 84	Yrs.	MOTHITS Days	riodis iviii.	May 11,		Jersey
Р.		Usual Residence of Decedent	10.00	<b>T</b>					404 1-14 05 11 5
hylar how	_	10a. State 10b. County		Town or Lo	cation				10d. Inside City Limits 1 X Yes 2 □ No
Sa-f	cto	MD Wicomico	De	lmar					
or 2	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	ountry?
23a	ra	105 East Pine Stree			21875			U.S.A.	
r de	Funeral	Ar	as Decedent Ever in U.S med Forces?	. 13. V	Vas Decedent of H Yes, specify Cuba	ispanic Origin? (S) In, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
s afte	by F	1 Never Married 2 Married 1   1   1   1   1   1   1   1   1   1	☐ Yes 2 📆 No Yes, Give ear or Dates:	1	☐ Yes 21X No	Specify:		Specify:	White
Pour Pour				16a Dagas	lent's Usual Occup	200		6b. Kind of Busines:	
72 2	Completed	15. Decedent's Education (Specify only highest grade com	pleted)	(Give	kind of work done of NOT use retired	during most of wor.	king	ob. Killa of busiles:	smoustry
then within	Ĕ	Elementary/Secondary (0-12) Co	ollege (1-4or 5+)		lomemaker	•		Home	
Hygin H		17. Father's Name (First, Middle, Last)			IOMCMARCI		ne (First, Middle, M		
d be file	o Be	Raymond Shedaker				Lillie	Johnson		
at y fattur Z i Z i 3-0030 should be filed within 72 hours after death with the Maryland nord Mental bygiene. The light of items 23a or 28a-f show marked other than "naturel", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	٩	19a. Informant's Name/Relationship (Type, Pi	rint)	19b. Mailin	a Address (Street			City or Town, State,	Zip Code)
d 2 s d 2 s d 2 s trau trau	R		ughter)		elaware				940
Heal G		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name of			Oc. Location - City o	
nt of mit		1 ⊠ Burial 2 □ Cremation 3 □ Remov	al from State	•	natory`or other plac	1	1 2006	D.1	. 1
politically individual years and 2 should be lied within 72 hours after death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Important: If them 27 is marked other then "naturel; or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once.	. 4	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee	St.	THE RESERVE OF THE PARTY OF THE	the second secon	and the second second		Delmar, D	elaware
Depa Depa Impo		21. Signature di Fundiai Service Cicensee			Name and Address Short Fun			T 100/0	
	-	220 Parts Enterthadisease examplifation	s that caused the death				Delmar, D		Approximate
		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau				g, such as cardiac	or respiratory arre-	, ,	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition resulting in death)		Abdon	new				
/Medical Examiner		resuming in death)	Due to (or as a conseque	ence of):					
	٠.	Sequentially list conditions, b.	Due to (or as a conseque	anna of\:					
pe is	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	silos oi).					
and I-trar	Examine	that initiated events c	Due to (or as a conseque	ence of):					
the death certificate be executed the death certificate be executed by the attending physicien and iched for use as the burial-transit	a E								
cate phys	dical	d							
death certific	Physician/Me	IF FEMALE: 23c If	yes, outcome of pregnan	cv				22d Date of d	- li
atten atten for us	ian	in the past 12 months?	Live birth 2 Fetal of Pregnant at time of dea	death 3	Ectopic pregnancy Other (specify)	,		23d. Date of do Month	Day Year
. ed the	ysic		Unknown	attri 5L	Ciner (specify)				
wrequires that the de been signed by the should be detached		Part II. Other significant conditions contribut	ing to death but not resul	ting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
requires that requires that seen signed be deta	ğ	•	•		,,				Probably 4.70Unknown
w requires been sign should be	Completed								
e 2 sl	du						24a. Was an autopsy perform	24b. Were a prior to death?	autopsy findings available completion of cause of
sicion: The law scertificate hes b lirector, page 2 si	Co								s 2 No
clen	Be	25. Was case referred to medical examiner?	-1-		104		ath (Check only one	)	
ding Physicien: th. After this certifice funeral director,	ျှ	1 ☐ Yes 2 No Hospit	1 Minpatient 2 L		t 3 DOA	4 U Nursing H		nce 6 Other (Sp	ecity)
ing F	uo.	Validation of the state of the	a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wor		28d. Describe how	w injury occurred	
DIVISION  I or Attending after death. Director: After Jin by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No	006 1		2 - 17 11 - 1
pr At the direct of the color o	ertification;	4 Homicide determined 28	<ul> <li>e. Place of Injury - At hon building, etc. (Specify)</li> </ul>	ne, farm, str	eet, factory, office		City or Town,		Rural Route Number,
urs a	O								
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After gone, tely filled in by the funeral process.	icai	29a. Certifier 1 Certifying Physician (Check only 2 Medical Examiner: C	<ol> <li>To the best of my know on the basis of examination</li> </ol>	riedge, death on and/or in	n occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	e, and due to the car irred at the time, da	use(s) and manner a te and place, and di	as stated. ue to the cause(s)
within 2 To the	Medi	29b. Signature and this of centriler	nu manner stated.		29c Licens	e number	90	d. Date signed (Mor	oth Day Year)
5 1 E C S		250. Signature and price of certified			H	115921		/ / s	1 22/
		The contraction			// 6	- 7 O Q		1-30-	cool
50		29b. Signature and this of certifier  29b. Signature and this of certifier  30. Name and a ress of person who comple  31. Date filed (Month, Day, Year)  FEB 0 1 2006	ted cause of death (Item	23a) (Type,	Print)	111	shin m	o sional	
J		John Yaul VisioLi 31. Date filed (Month, Day, Year)	32 Renistrar's Signatur	0 E · C	MARUIJ ON	. 3/44.	noung in	21004	
Sta	ite ar	EED 0 1 2000	JE. Jugistrai o digitati	0					

			State of Maryland / Dep 1 - For State Registrer Amend#10ePer FH PCC 2-1-06 cr Ce	partment of Health and Mertificate of Death	lental Hygie	anna allai
	Physici	an	1. Decedent's Name (First, Middle, Last)  Nevada C. Jackson		2. Date of Death Month	Day Year 8.20 6 M
	/Medio Examin		4a. Facility Name (If not institution, give street and number) Manor Care Nursing Home	4b. City, Town, or Location of Death Silver Spring	1	4c. County of Death Montgomery
	Funeral Director		5. Social Security Number  249-58-2843  6. Sex 1 M 2 F F F F F F F F F F F F F F F F F F	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Ye Aug. 19,	9. Birthplace (State or Foreign Country) 1922 South Carolina
	ryland thow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L  Manual and During County County 1 Town			10d. Inside City Limits
	ith the Ma or 28e-f s	Director	Maryland Prince George Capitol E  10e. Street and Number  1321 Farmindale Avenue	10f. Zip Code 20743		1 ⊠Yes 2 □ No Citizen of What Country?
36	a within 72 hours after death with the Maryland Jiene. r than "natural", or Items 23e or 28e-f show The Medical Evantral must be notified at	by Funeral	Farmingdale  11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Yes, Give	. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian, Black, White, etc. Specify: Black
21215-0036		Completed b	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0·12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of worki DO NOT use retired)	ing 16t	b. Kind of Business/Industry
and 21	be filed tal Hyg rd othe event,	Be	8th Ma 17. Father's Name (First, Middle, Last) William E. Foote	atron  18. Mother's Name  Lula Mo	e (First, Middle, Mail	Private  den Sumame)
Maryland	s 1 and 2 should be f Health and Mental I item 27 Is marked of other treumetic eve	7	19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ling Address (Street and Number or Rura	al Route Number, C	ity or Town, State, Zip Code) Heights, MD. 20748
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 Is any injury or other tre			ematory or other place)		c. Location - City or Town, State
Balti	permit Departn Importe any inju		June Still hold	22. Name and Address of Facility Por 55 For	Funeral 38 Maribon restville	, MD. 20747
	Medical Examiner bunsician and physician and	Examiner	23a. Part 1. Enter the disease or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, lid 1, Hadon of immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	hiratory arre	or respiratory arrest,	Approximate Interval Between Onset and Death
P.O. Box 68760,	The law requires that the death certificate be executed as been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical		□Ectopic pregnancy □ Other (specify) underlying cause given in Part I.	23e. Did tobac	23d. Date of delivery  Month Day Year  co use contribute to the cause of death?
Vital Records,		Completed by	HTN, DH dements	a obesity	1 Yes  24a. Was an autopsy performed 1 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?
Division of Vita	Attending Physicien: death. ctor: After this certific y the funeral director,	Certification; To Be	25. Was case referred to medical examiner?  1	ont 3 DOA Other: 4 Nursing Ho of 28c. Injury at Work? M 1 Yes 2 No	28d. Describe how i	at and Number or Rural Route Number,
	Hospita 4 hours Funeral tely filled	Medical Ce	29a. Certifier (Check only one)  29 Medicel Examiner: On the basis of my knowledge, deal and manner stated.			
	To the within 2 To the complei	Me	29b. Signature and title of certifier	29c. License number  00055362		Date signed (Month, Day, Year)  - SO - O6  - So- Sur (2000)
-	Sta Registi		31. Date filed (Month, Day, Year)  JAN 3 1 2006  Registrar's Signature		N 2085	2

			. For	State of M						•			01105
			1 - State Registrar			Cei	rtificate o	f Death			Reg. No.	UUb	04425
	Physicia	an	1. Decedent's Name (First, Middle, La	st)						<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of Death
	/Medic	al	Robert Jordan, 4a. Facility Name (If not institution, giv				4b. City, Town	or Location	of Death	01	28	06 County of Deat	5:00 P <sup>M</sup>
	Examin	er	Clinton Nursing				Clintor		or Death			,	Georges
	Funeral		5. Social Security Number 6. S	ex 7. Ag	ө (In yrs.	last birthday)	If Under 1 Year Months Day	ar If Under	24 Hrs. Min.	8. Date of Birt (Month, Da	h	9. Birti	nplace (State or Foreign untry)
	Director		578-60-9512 Usual Residence of Decedent	M 2□F 5	8	Yrs.				08-01			ington, DC
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation			<u> </u>			10d. Inside City Limits
	death with the Maryland rms 23e or 28e-f show	ctor	DC		Wa	shingt	on						1to Yes 2 □ No
	or 28	Funeral Director	10e. Street and Number				10f. Zip Code	•			10g. Citiz	en of What Co	untry?
	eath v	eral	807 Chesapeake St	reet, SE	Ever in II	S 13 1	2003		igin? (Spec	cifu Yes or No.		US 4. Race - Ame	ocan Indian
0	r Item	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑			Was Decedent of Yes, specify Co			Rican, etc.)		Black, White	
0000-CI	ours a	d by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			1□Yes 2⊠N	lo Specify:				Specify: B1	ack
ה	"netu	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usual Occ kind of work dor DO NOT use reti	cupation ne during mos	t of workin	ig	16b. Kir	nd of Business/	Industry
717	within iene. than	omo	Elementary/Secondary (0-12)	College (1-4or	5+)	_	penter	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		i	D.C.	Govern	ment
2	e filed al Hyg other vent,	Be C	17. Father's Name (First, Middle, Last	)				18. Mothe	er's Name	(First, Middle,			
yland	ould b Menta arked	To	Michael Jones							P. Par	-		
Mar	12 sh h and 7 Is m treum		19a. Informant's Name/Relationship (				ng Address (Stre						
ā -	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "neturel; or Items 23e or 28e-1 show amportent: If item 27 is marked other than "neturel; or Items 23e or 28e-1 show ampring intro or other treumetic event, the Medical Eventual for mall fee intiffied at once.		Robert Jordan, J1 20a. Method of Disposition	<u> </u>	20b. P	lace of Dispo	nesapeak sition (Name of			ate Was		cation - City or	
Бант	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special				natory or other p Cemeters	1	02-0	4-06	Land	lover, 1	4D
<u>a</u>	permit. Departminitimporte any inju		21. Signature of Funeral Service Lice	nsep · 11	/		2. Name and Add						
0	60 E 2 9		Peric D. S	trecklas	d		500 A11e				_	ngs, M	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each li	ne.				cardiac or	respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. <u>Cardio</u> Due to (or as			Failur	e					
	Examiner		Sequentially list conditions	h Metasta	atic	Lung O	ancer						
	be sit	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a conseq	uence of):							
	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	c. AIDS  Due to (or as	a conseq	uence of):							
/oC,	ate be executed nysician and he burial-transit	calE	· ·	d									
å	certificat nding phy use as th	_	IF FEMALE:										
X D D	death ce e attendi ed for use	lan/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome	2 Feta	I death 3	Ectopic pregnar				2	3d. Date of del	very Day Year
5	the de y the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant a 9□Unknown	t time of a	eath 5L	Other (specify)						
7	law requires that the death certifica as been signed by the attending ph. 2 should be detached for use as th	by Pr	Part II. Other significant conditions	contributing to death b	out not res	ulting in the u	nderlying cause	given in Part I	١.	23e. Did to	obacco u	se contribute to	the cause of death?
Records	equire en sig ould b		Seizure Disord	er						101	/es 2[	No 3□Pr	obably 4 🔀 Unknown
ဒို	law r	Completed								24a. Was autop	sy	prior to d	topsy findings available completion of cause of
	sicien: The law certificate has t irector, page 2 s									1 ☐ Yes		death?	2 No
VItal	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2∑ No	Hospital: 1 ☐ Inpati	ant 2 🗆	ER/Outpatier	t 3 DOA	Other		(Check only o		□Other (Spec	cify)
0	tding Physicien: th. After this certifical funeral director,	T:uc	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	iry	28b. Time or		ijury at Vork?		8d. Describe h			
SIO	tendir leath. lor: Af the fur	catlc	2 Accident investigatio	n			M 1	Yes 2					
UNISION	or At after d Direct in by	ertification;	4 Homicide determined		ury - At ho c. (Specif	ome, farm, str y)	eet, factory, offic	Ce .	2	City or Tov			ral Route Number,
_	To the Hospitel or Attending within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	0	29a. Certifier 1⊠ Certifying Pt	ysician: To the best	of my kno	wledge, deat	h occurred at the	time, date ar	nd place, a	nd due to the	cause(s)	and manner as	stated.
	in 24 I in 24 I ihe Fu	edical	one)	miner: On the basis of and manner st		tion and/or in			ath occurre				
	Vith To 1	Σ	29b. Signature and title of certifier		15			ense number				signed (Monti	n, Day, Year)
	15		30. Name and address of person who		leath (Ita-	23a) /Tunc		)999			01/3	1/06	
	(2)		Aruna Paspula, M					er, 106	Irv	ing Str	eet,	DS 2415	ōS, Wash.,
	Sta		31. Date filed (Month, Day, Year)	2. Registi	ar's Signa	ture							<b>-</b>
	Registr	ar	FEB 0 1 2001	Milan	, JK	Ann	w						

		·	For State Registrar			f Marylan		artmen rtificat			and M		Reg. N	000	marine 3	426
1	Physici /Medio			Jones,	r.			4 00	<del>-</del>		(5.4)	2. Date of D Month Januar	y 28	s, 20ď6	9:	20 P M
-	Examir	er	4a. Facility Name		give street and nui	mber)			kvil	le Location o	or Death		40	County of De Montgoi		
	Funeral Director	20.540	5. Social Security 577-34-	Number	6.Sex 1	7. Age ( <i>i</i> n <i>yr</i> s. <b>7</b> 8	last birthday) Yrs.	If Under Months	Days	If Under Hours	24 Hrs. Min.	8. Date of B Dec . I	irth ay, Year	9.6	Sidbplace (Si	on, DC
	and		Usual Residence	10b. County		10c. Cit	y, Town or Lo	ocation					<del></del>			de City Limits
	Mary	tor	D.C.	N/A	1	W	ashing	ton							1 (3	Yes 2□No
	or 28	Direc	10e. Street and N					10f. Zip						itizen of What		
	9eth w	eral	4520 E	dson Pla	ce, N.E.	edent Everinil	S. 13.		019 dent of Hi	spanic Ori	ain? (Spe	ocify Yes or N	- 7	ted St		an,
36	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Importent: If Item 27 ie marked other then "natural", or Iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examinational be notified.	Completed by Funeral Director	1 Never Mai	ried 2 Marri	Armed Formation of Displayment Armed Formation of Displayment	edent Evering 195 rces? 195	3	If Yes, spe		n, Mexican Specify:	, Puerto	ecify Yes or N Rican, etc.)		Black, W		
8	2 hour	ted t		15. Decedent	s Education		16a. Dece	dent's Usu	al Occupa	ation	t of worki	20	16b. I	Kind of Busine	ss/Industry	
21215-0036	ithin 7 ne.	nple	Elementary/Sec		grade completed) College (	1-4or 5+)	life.	rieto	se retired	iding mos	i oi workii	ig.	Sho	e Shin	o Darl	or
7	Hygier Hygier ther th	Col	12 17. Father's Name	(First, Middle, L	ast)		гтор	11600	1	18. Mothe	er's Name	(First, Midd)			- laii	-
au	lid be fental rked o	To Be	Frank J	ones, Sr	`•					Bert	ha P	rice				
Maryland	d 2 shouth and N		19a. Informant's P			on)						Iver S		or Town, State	20902	
	other		20a. Method of Di	sposition	-	20b. F	Place of Dispo cemetery, crea		•			ate	<del>,</del>	ocation - City	or Town, Sta	ite
<u>=</u>	Page ment c ent: If			5 ☐ Other (Sp	3 □Removal from ecify)	State Q	uantic	o Nat	iona	1	2/7/			angle,		
Baltimore,	Departi Departi Importi eny Inj		21. Signature of E	nolo	Thom	Sou								al Ser	vice 2001	2
o'c	Physician /Medical Examiner	Examiner	shock, or he Immediate Cause disease or condit resulting in death  Sequentially list or any, leading to cause. Enter Unc. Cause (Disease or that initiated even resulting in death)	ant failure. List of (Final on )  onditions,  minediate lerlying  r injury ts	b. Due to	tastati (or as a conseq (or as a conseq	c Pros				cardiac	, respiratory	unesi,		Interva	ximate al Between and Death
P.O. Box 68760,	the death certific by the ettending p sched for use es i	by Physician/Medical	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow	2 months?	1 ☐ Live t 4 ☐ Pregr 9 ☐ Unkn		ll déath 3[ leath 5[	⊒Ectopic p ⊒ Other <i>(s</i> į	pecify)			-75 =		23d. Date of o	Day	Year
	res tha signed I I be det		Part II. Other sign	ificant conditio	ns contributing to d	eath but not res	ulting in the u	inderlying o	cause give	en in Part I	,			use contribute No 3 □		
Vital Records,	ie law require has been sig ge 2 should b	Completed										24a. Wa aut per	s an opsy formed?	24b. Were prior death	autopsy find to completion	lings available to of cause of
tal		Be Co	25. Was case refe	erred to medical						26. Place	of Death	1 Yes		o 1□Y	′es 2□No	)
Ž	iding Physicien: th. : After this certifice funeral director. p	To B	examiner?	X No			ER/Outpatie	nt 3 D	OA Oth	er: 4□Nu	ırsıng Hoi	me 5∐Re	sidence	6 X Other (S	pecify) ho	spice
0 0	ing P? After th uneral		27. Manner of Dea	5 Pending		of Injury th, Day Year)	28b. Time o Injury		28c. Injun Worl	yat k? Yes 2 □		28d. Describe	how inj	ury occurred		
Division of	or Attender fler dea Director in by the	Certification;	2 Accident 3 Suicide 4 Homicide	investig 6  Could n determi	ot be 28e. Place	of Injury - At hing, etc. (Specif	ome, farm, st (y)	m reet, factor		105 2		28f. Location City or T		ind Number or te)	Rural Route	Number,
_	Hospite 14 hours Funerel tely filled	Medical C	29a. Certifier (Check only one)	Certifying	Physician: To the examiner: On the b and man	best of my kno asis of examina ner stated.	owledge, deat ation and/or in	h occurred ivestigation	at the tin	ne, date ar pinion, dea	nd place, ath occurr	and due to th ed at the time	e cause( e, date ar	s) and manner nd place, and c	as stated. due to the ca	use(s)
	within 2 To the	Me	29b. Signature an	d the of certifier				29	c. Licens	e number				ate signed (Mo		
)	6+1		•	- HK1	~	w	77	D	3563	5			Jan	uary 2	7, 200	6
					who completed caus	se of death (Iter	n 23a) (Type,	Print) Mill	Pos	d Do	ckvi	M عاا	ס מ	0355		
#10	Sta	to	Joseph 31. Date filed (Mo	Kaplan nth, Day, Year)					Nua	u, Nu	CKVI	11C 1	<i>U</i>	.000		
7.0	Registi		FF		006	We the	ature									

			For State Registrar	State of I	Maryland		artment of tificate of		and M		giene	nnc	044	27
			1. Decedent's Name (First, Middle, Las	t)						2. Date of Dea Month			3. Time of	Death
	Physici /Medic		JESSE J. JOHNSON							JANUARY			5:45	P M
	Examin		4a. Facility Name (If not institution, give	street and number	er)		4b. City, Town,	or Location of	of Death			County of Dea		
			MANOR CARE OF SILVE				SILVER		04 13-0			MONTGOME		
	Funeral Director		323-14-3704	X	Age (In yrs. Ia 84	Yrs.	Months Day		Min.	8. Date of Birth (Month, Day 7/14/19)	Year)	9. Bi	rthplace (State o ountry) SOURI	r Foreign
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City.	Town or Lo	cation						10d. Inside Ci	ty I imits
	daryl f sho	o	NEW YORK WESTCHEST	rer			-HUDSON						1 ÄYes	•
	28a	Director	10e. Street and Number	-	- Ore	01011 011	10f. Zip Code		<u> </u>		10g. Citi	zen of What C	ountry?	
	h with	O JE	16 SPICE HILL ROAD				1052	0			IJ	SA		
	deat	Funeral	11. Marital Status	12. Was Decede Armed Force			Vas Decedent of Yes, specify Cu	Hispanic Original	gin? (Spe	cify Yes or No-		14. Race - Am		
98	or It	y Fu	1 Never Married 2 Married	1 X Yes 2[ If Yes, Give			I ☐ Yes 2 ☐ N		, 1 00110	riicari, etc.)		Black, Whi	te, etc.	
Ö	hours tural',	d by	3 Widowed 4 Divorced	Year or Date	s: WWII					1	1.51 1.51	AFR	ICAN-AMER	ICAN
21215-0036	within 72 hours after death with the Maryland ane. than "natural", or Items 23a or 28a-1 show he Medical Exama her must be notified at	Completed	15. Decedent's Edi (Specify only highest grad	le completed)		(Give	lent's Usual Occi kind of work don DO NOT use retii	e durina mosi	of worki	ng	16b. Ki	nd of Business	Mindustry	
212	iene.	omp	Elementary/Secondary (0-12)	College (1-4d	or 5+)		CAL PSYCH	•			MEN	TAL HEAT	TH SERVIC	ES
פָּ	e filec al Hyg othe vant,	BeC	17. Father's Name (First, Middle, Last)						r's Name	(First, Middle,				
/lar	Ments Ments arked stic a	ToE	JESSE JOHNSON					SAI	ŖAH	ROBINSON				
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injuy or other traumatic avant, the Medical Example of the modified at once.		19a. Informant's Name/Relationship (T			19b. Mailin	g Address (Stree	et and Numbe	r or Rura	l Route Numbe	r, City o	r Town, State,	Zip Code)	
2 0	l and fealth im 27 her tr		ANNIE R. JOHNSON - WI	IFE	Joh Bla		GRACEFIELI	O ROAD A						
Baltimore,	in it of the		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I		te cer	metery, cren	sition (Name of natory or other pl	·				cation - City or		
ij	it. Partitude ortant		<ul> <li>4 □ Donation 5 □ Other (Specify,</li> <li>21. Signature of Funeral Service License</li> </ul>		FOR.		LN CREMATO	1	1/31/			TWOOD, M		
Ba	perm Depa Impo any i		Mexint. 6	lebat	)		. Name and Add 1800 NEW							
П			23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	lications that caus ne cause on each	sed the death. I line.	Do not ente	er the mode of dy	ing, such as	cardiac o	r respiratory arr	est,		Approximate Interval Bety	ween
	Physician		Immediate Cause (Final disease or condition	a. GLIOBI	LASTOMA :	TUMOR O	F THE BRA	IN					Onset and D	
	/Medical Examiner		resulting in death)	Due to (or	as a conseque	ence of):								
b	Ş4.	-	Sequentially list conditions,	b. — Due to (or a	as a conseque	ence of):								
	uted d ansit	Examiner	if any, leading to immediate Cause (Disease or injury that initiated events											
o,	be executed sician and burial-transit		resulting in death) Last	Due to (or	as a conseque	ence of);								
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit	dical		d.										
9	artifica ing ph e as t		IF FEMALE:											
Вох	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?		2 Fetal o	death 3	Ectopic pregnan	су			2	23d. Date of de Month		'ear
o.	at the de by the a tached t	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∐Pregnant 9☐ Unknown	at time of dea	ath 5∟	Other (specify)						,	
۵.	that the	/ Ph	Part II. Other significant conditions co	ntributing to death	but not result	ting in the ur	iderlying cause g	iven in Part I.		23e. Did to	bacco u	se contribute t	o the cause of d	eath?
rds,	uires n signe	d by	SEIZURE DISORDER							1 □ Y	es 2[	ŽNo 3□P	robably 4 🗀 U	Inknown
Record	s been si	ompleted								24a. Was a			utopsy findings a	
	The law ite has b bage 2 sl	lwo			-		,			autops perform		death?	completion of ca 2 □ No	luse of
Vital	ysician: The l is certificate ha director, page	BeC	25. Was case referred to medical examiner?					26. Place	of Death	(Check only or		1	- 10110	
	Physician: r this certific ral director,	P,	1 ☐ Yes 2 🙀 No	Hospital: 1 ☐ Inpa		P/Outpatien	3 DOA	-	rsing Hor	ne 5 🗆 Reside	ence 6	Other (Spe	ecify)	
n c	ing P	on:	27. Manner of Death 1 Autural 5 Pending	28a. Date of Ir (Month, I	njury Da <i>y Year</i> )	28b. Time of Injury		ork?		28d. Describe h	ow injun	occurred		
isi	l or Attanding after death. Director: After in by the funer	icat	2 Accident investigation 3 Suicide 6 Could not be	29a Place of	Injunt - At hom	no form otre	M 1 [	]Yes 2⊡l	_	19f Location (S	troat as	d Number or O	ural Route Numi	har
Division of	lor A after Direct	Certification:	4 Homicide determined	building,	etc. (Specify)	io, iaiiii, stie	et, ractory, office	,	1	City or Town	n, State)	)	urar moule raini	<i>761</i> ,
	spita nours neral	aC	29a. Certifier Certifying Phy	sician: To the be	st of my know	ledge, death	occurred at the	ime, date an	d place, a	and due to the c	ause(s)	and manner a	s stated.	
	To the Hospital or Attanding within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.	edical	(Check only 2 Medical Examone)	inar: On the basis and manner	s of examination	on and/or inv	estigation, in my	opinion, deat	h occurre	ed at the time, d	ate and	place, and du	e to the cause(s)	
	To the to the comp	Σ	29b. Signature and little of certifier	1-	-1	^	29c. Licer	se number	_	2		signed (Mon	1	
)	8		Maman	X' -	Ch	y,	121	460	9		1:3	30-06		
			30. Name and address of person who c				-							
	-0			503 PERRY	-td O'	1.0		NIER MD	2071	2				
	Sta Registr		31. Date filed (Month Pay, Year) FEB 01 20	06	strar's Signatu	Rose	well !							

			1 - For State Registrar	State of Maryla	nd / Depa		Health and	d Mental Hy	•	04428
	hysicia Medic	al	1. Decedent's Name (First, Middle, Last)  Jacob Charles Jablon			2. Date of Dea January 4b. City, Town, or Location of Death				3. Time of Death 11:50A <sub>M</sub>
	xamine	er	4a. Facility Name (If not institution, give s Manor Care Bethe	esda		Betheso	la, Maryl	and.	Montgome	ry County
	neral ector		5. Social Security Number 121-05-8955 6. Sex 1X	7. Age ( <i>In yr</i> s 97	Yrs.	If Under 1 Year Months Day		in. Decembe	rth (1908 Co	hplace (State or Foreign bustry) New York
d 21215-0036 filled within 72 hours after death with the Maryland Hygiene.	Department of Health and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show any injury or other traumatic event. Ite Medical Exercities must be ricitling at once.	ector	10a. State 10b. County  Maryland Baltimor  10e. Street and Number		ity, Town or Lo	own			100 Citizen et Mine Co	10d. Inside City Limits 1 ☐ Yes 2X No
ath with a		ral Dir	3717 Lanamer Road			10f. Zip Code 2113			10g. Citizen of What Co United Stat	
036 ours after dea		by Fune	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in t Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedento If Yes, specify Ci 1☐ Yes 2【 N		(Specify Yes or No erto Rican, etc.)		
vithin 72 ho		ompleted	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	cation e <i>completed)</i> College (1-4or 5+)	16a. Dece (Give life. Audi		cupation ne during most of v red)	vorking	16b. Kind of Business/	
Maryland 21215-0036  d 2 should be filed within 72 hours aff thand Mental Hygiens 71 is marked other than "natural" or		To Be C	17. Father's Name (First, Middle, Last) Abraham Jablon				Sophie	Reuben	i , Maiden Sumame)	
Mar and 2 sh alth and	ar traum		19a. Informant's Name/Relationship (Ty) Arnold Jablon-son	pe, Print)					wer, City or Town, State, 2 ${ m Wn}$ , MD $2113$	
nore ages 1 and the	d de		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	onioval nomi plate	Place of Dispo cemetery, crei	esition (Name of matory or other p		Date / 29/06	20c. Location · City or	
Baltimore, permit. Pages 1 ar Department of Hea	any infur-		4 Donatten 5 Other (Specify) 21 Signature to theral 2 nace Licens		22	2. Name and Add	tress of Facility ${ m E}_{ m C}$	lward Sag	Adelphi, M el Funeral ville, MD 2	Direction
/Med Exam	within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physicien and Dip Dip Completely filled in by the funeral director, page 2 should be detached for use as the burial-transit a DIP DIP DIP DIP DIP DIP DIP DIP DIP DIP	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that intilated events resulting in death) Last	Due to (or as a consection of the consection)  Due to (or as a consection)  Due to (or as a consection)  Due to (or as a consection)	R FIBRI quence of): RTERY D	LLATION	-	lac of respiratory a	iffest,	Approximate Interval Between Onset and Death
I Records, P.O. Box 68  The law requires that the death certifical		by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of to 9 □ Unknown	al death 3[	Ectopic pregnar Other (specify)			23d. Date of del Month	ivery Day Year
ords, P.		e Completed by Ph	Part II. Other significant conditions con	tributing to death but not re	sulting in the u	nderlying cause	given in Part I.		tobacco use contribute to Yes 2 No 3 ☐ Pr	the cause of death?
Vital Records, sicien: The law requires t			25. Was case referred to medical					1 Yes	psy prior to death?  2⊠No 1 □ Yes	itopsy findings available completion of cause of 200 No
_ > "		To B	examiner?	Comparing   Comp						cify)
DIVIS  I or Attended after deal		edical Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Right City or Town, State)					ıral Route Number,	
Hospitel or 24 hours afte			29a. Certifier (Check only one)  Check only one)	sician: To the best of my kn ter: On the basis of examin- and manner stated.	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date and play opinion, death of	ace, and due to the courred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
To the within 2		Me	29b. Signature and title of certifier	1.00		29c. Lice	nse number		29d. Date signed (Monti	
3			30. Name and address of person who co-			Print)	051280		January 28	
	Sta		Anushiravan Dadgar 31. Date filed (Month, Day, Year)	13219 Execu			ace Ger	mantown,	MD 20874-26	547
R	egistr		FEB 0 1 200	Registrar's Sign	A ASSESSED	NESS!				

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Alieu Kamara January 26,2006 2:25 P /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Hospice of Chesapeake Lithicum Anne Arundel If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, May 12 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 213-51-6261 27 Yrs ,1978 Director May Freetown, S.L. Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if item 27 le marked other then "natural", or items 23a or 28e-f ehow eny injury or other treumatic event, the Medical Examinar must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Director MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1213 Stockport Ct. 20721 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ②☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 2yrs Elementary/Secondary (0-12) Airplane Ticketer Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Abass Α. Kamara George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Karamoh Jalloh/Uncle 1213 Stockport Ct. Bowie, MD 20721 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State George Washington 1/29/06 4 □Donation 5 □Other (Specify) Adelphi, MD 22. Name and Address of Facility J.B. Jenkins Funeral Home 21. Signature of Funeral Service Licensee 7474 Landover Rd. Landover, MD 20785 23a. Part1. Enter the disease. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Approximate Interval Between Onset and Death List only Immediate Cause (Final disease or condition resulting in death) PROGRESSIVE ASTROCYTOMA **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed the ettending physicien and hed for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ś 2 should be 3 Probably 4 X Unknown 1 ☐ Yes 2 ☐ No Be Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 1 Yes 2⊠ No 1 ☐ Yes 2X No To the Hospitel or Attending Physician: : After this certification funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 Nursing Home 5 Residence 6 MOther (Specify) Hospice Hospital: 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury 5 Pending М 1 TYes 2 No investigation 2 Accident filled in by the **Director:** 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours after To the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Monny 1) 1/30/2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 Victor Priego M.D. 6420 Rockledge Drive # 4100 Bethesda, Maryland 20817 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JAN 3 1 2006

			For State Registrar	State of Marylan	d / Depa		lealth and l	Mental Hyg	•	04430						
	ysicia Jedic		1. Decedent's Name (First, Middle, Last)  Lamoon KCOWPlunG					2. Date of Death Month	h Day Year 25 2006	3. Time of Death						
Examin Funeral		er	4a. Facility Name (If not institution, give s つといっかっしい とていいをいしを 5. Social Security Number 6. Sex	ast birthday) Yrs.	4b. City, Town, Frederic  If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth	Freder Year) 9. Bir	4c. County of Death  Frederick  ear)  9. Birthplace (State or Foreign County)  THAILAND							
ō.	rector Mount	10	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Ir													
h with the M	at be notifie	al Director	MD   Montgo	antown  10f. Zip Code  20874			Og. Citizen of What Co									
mit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Heatth and Mental Hygiene.	Examiner mu	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Midowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 Min No If Yes 2 Give Year or Dates:			Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ☐ Yes 2 ☒ No Specify:			14. Race - Ame Black, Whi	14. Race - American Indian, Black, White, etc.						
ad within 72 hours af giene. ar than "natural", or	the Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 4 th	(Give	dent's Usual Occupation kind of work done during most of working DO NOT use retired)  Housewife			6b. Kind of Business/Industry  Home								
nd 2 should be filed withir lith and Mental Hygiene. 27 is merked other then	atic event,	To Be C	17. Father's Name (First, Middle, Last)  Had Kemthong  Jorm Kemthe						Maiden Sumame) hong							
and 2 sho ealth and i m 27 is m	ner traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Prinda Suntararak (Daug)  19d. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  19403 Ridgecrest Dr., Germantown, MD 208													
permit. Pages 1 and 2 Department of Health a Important: If item 27 is	any injugy es ott		20a. Method of Disposition  1 Burial 2 Cremation 3 R  4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licence	emoval from State Met	ro F		Serv 1	-26-06 NOWDEN 1		ria, VA HOME, P.A.						
Physic /Med Exami	ian ical		shock, or heart failure. List only one cause at each line.							Approximate Interval Between Onset and Death						
te be executed ysician and	e burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.													
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es ti			Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						acco use contribute to	o the cause of death? robably 4 Munknown						
sician: The faw requir	, page 2 sho	Completed						24a. Was ar autopsy perform 1 Yes 2	y prior to ned? death?	utopsy findings available completion of cause of 2 Mo						
ding Phy h. After this	Director: After tin by the funera	To B	10 B	To B	10 B	Certification: To Be	10 B	To B	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 I	ER/Outpatier 28b. Time o Injury	28c. Inju	her: 4 Nursing H	th (Check only one ome 5 Reside 28d. Describe ho	nce 6 ☐Other (Spe	icity)
e Hospital or Attending 24 hours after death.									ocation (Street and Number or Rural Route Number, ity or Town, State)							
To the within 2	completely	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and and manner stated.							ete and place, and due	th, Day, Year)						
2	Stat	9	30. Name and address of person who co Item & Sharh, 31. Date filed (Month, Day, Year)	mpleted cause of death (Item	23a) (Type,	Print)	n by	Freder	ICK K	15 2170L						

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Physician January 29, 2006 Gladys Kaplan 1:00 AM /Medical 4b. City, Town, or Location of Deeth 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Yeer) 11/1/1909 9. Birthplace (State or Foreign Country) Massachusetts 5. Social Security Number 7. Age (In yrs. lest birthday) **Funeral** Months Days Hours 1 □ M 2X F 326-26-0285 96 Yrs. Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Meryland Department of Health and Mental hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic event. The Medical Examiner must be notified at DRGs. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Montgomery Rockville 1 N Yes 2 No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 14 Welwyn Way 20850 United States Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Maritel Status 12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: white Completed by 3 X Widowed 4 ☐ Divorced Yeer or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) 1 2 College (1-4or 5+) homemaker own home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Harris Scholnick Ida Roybard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Janice Perry-daughter 14 Welwyn Way Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State Shalom Memorial Park 1/31/06 4 ☐ Donetion 5 ☐ Other (Specify) Palatine, IL 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 1091 Rockville Pike, Rockville, Maryland e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical hypertensive heart disease Examiner Due to (or as a consequence of): Physician/Medical Examiner Alzheimers dementia signed by the attending physician end d be deteched for use as the bunal-transit or Attending Physician: The law requires that the death certificate be exacuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. sepsis that initieted events resulting in death) Last Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown depression Ś Completed 24b. Were autopsy findings available prior to 24a. Wes en autopsy hyperlipidemia completion of cause of death? 1 □ Yes 2 NINO 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours efter death.

To the Funeral Director: After this completely filled in by the funeral of 28b. Time of Injury 28a. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturel 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the ceuse(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Yeer) D0047330 January 29, 2006 womms DIMI 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print)

DHMH 16 Rev 6/95

State

Registrar

Thomas V. Joseph, MD

FEB

01

31. Date filed (Month, Day, Year)

Rockville, MD 20852

50 W. Edmonston Drive

32. Registrer's Signature

2005

_			State of Maryland / D	epartment of Health and Modernificate of Death	1ental Hyg	_	04432		
	Physic		1. Decedent's Name (First, Middle, Last) Anna Kathryn KING		2. Date of Deat Month	Day Year	3. Time of Death		
	/Medi Examir		4a. Facility Name (If not institution, give street and number) Fohrney-Keedy Nursing Hor	4b. City, Town, or Location of Death	<u> </u>	4c. County of Death	h		
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs last birth 172-05-7001 1□ M 2☒F 90 Yr	Months Days Hours Min	8. Date of Birth (Month, Day, January	9. Birth 8,1916	hplace (State or Foreign untry) Pennsylvania		
21215-0036		o	Usual Residence of Decedent         10a. State         10b. County         10c. City, Town           Maryland         Washington	r Location Hagerstown			10d. Inside City Limits 1 ☐ Yes 2 ☒ No		
		I Direct	108. Street and Number 10828 Lincoln Avenue	10f. Zip Code 21740	11	0g. Citizen of What Co USA	untry?		
		by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 Yes 28 No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White			
		Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation Give kind of work done during most of work ife. DO NOT use retired) borer	ing	16b. Kind of Business/l			
nand 2	permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic avant. It a Magnee.	To Be Co	17. Father's Name (First, Middle, Last) William Henry Brooks	18. Mother's Name	e (First, Middle, M aria Gro	Maiden Sumame)	aracturer .		
くい。, Ann Baltimore, Maryland	and 2 shore and 2 store and 27 is ma		Betty K. Neff - daughter 1	Mailing Address (Street and Number or Rura 0830 Lincoln Ave., I					
imore	Pages 1 annent of He ant: If iten ury or oth		TEACHER 2 CHARACTER 3 CHARACTER 1	disposition (Name of crematory or other place)  Aven Cemetery 2/3/		20c. Location - City or 1 Hagerstown ,			
⊼ Balt	permit. Departimont. Import		21. Signature of Funeral Service Licensee	415 E. Wilson Blvd.	MINNICH , Hagers	FUNERAL HO	ME		
8760,	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of	ra II I E		est,	Approximate Interval Between Onset and Death		
	% € <del>+</del>	dical Examiner	Sequentially list conditions, fany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b.	ià	lone		154		
P.O. Box 6	at the death certific by the attending partached for use as	Physician/Med	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy  1 □ Live birth 2 □ Fetal death  4 □ Pregnant at time of death  9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv	very Day Year		
rds, P	w requires that been signed to should be deta	by	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		acco use contribute to s 2 □ No 3 □ Pro			
Division of Vital Records,	ician: The law recertificate has beerector, page 2 sho	e Completed				prior to co death? No 1 Yes	opsy findings available ompletion of cause of		
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ivision	or Attanding Faffer death. Director: After in by the funer.	Certification:	27. Manner of Defath  1 Set Natural 5 Pending investigation 3 Suicide 6 Could not be determined 4 Homicide    28a. Date of Injury (Month, Day Year) 28b. Time Injury  28b. Time Injury  28b. Time Injury  28c. Place of Injury 28b. Time Injury  28b. Place of Injury 28b. Time Injury  2	ry Work? M 1 ☐ Yes 2 ☐ No		eet and Number or Rur	al Route Number,		
۵	Hospita 4 hours Funeral	edical Ce	29a. Certifier  (Check only one)  15 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.						
	To tha within 2 To the complet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number		d. Date signed (Month,			
	<i>u</i> ~		30. Name and address of person who completed cause of death (Item 23a) (Ty			1/1/0			
	H~フ Sta Registr	-	Dr. Waseem, Opal Court, Hagerstown 31. Date filed (Month, Day, Year) 32. Registrar's Signature						
	negisti	Al .	FEB 0 2 2006   Barrer A.	Goete					

		,	For State Registrar	State of M	laryland / Dep Ce	ertificate of		Reg	ene No. 0 0 6	04433
	Physici	an	Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death
	/Media		Helen Marie Kno						30, 2006	
À	Examir	er	4a. Facility Name (If not institution, git			,,	r Location of Death		4c. County of Dea	
			10940 Snethen C				la Spring If Under 24 Hrs.		Wicomico	
	Funeral			1 M 2 M F	ge (In yrs. last birthda)	Months Days	Hours Min.	(Month, Day, Y	eer) 3. Bir	thplace (State or Foreign
	Director		Usual Residence of Decedent		76 frs.			Jan. 30,	1930 Ma	ıryland
	ylend W		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	Man	호	MD Wicomi	.co	Mardel.	a Springs				1 ☐ Yes 2 ☑ No
	1284 T	<u>e</u>	10e. Street and Number			10f. Zip Code		10g	. Citizen of What C	ountry?
	3e o	읖	10940 Snethen C	hurch Roa	d	2183	7	U	.S.A.	
	d within 72 hours efter deeth with the Maryland Jiane. I than "neturel", or Iteme 23e or 28e-f ehow The Madical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent		. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (S	pecify Yes or No-	14. Race - Ame Black, Whi	
g	or the	립	1 Never Married 2 Married	1 Yes 2X		1 ☐ Yes 2 ☐ No	Specify:	o moan, etc.,	Cronife	
21215-0036	ours Fig.	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:			opouny.		Specify. W	hite
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121	within and the Mac	g E	Elementary/Secondary (0-12)	College (1-4or	5+)		2)		**	
72	filled of Hygis other f		9 17. Father's Name (First, Middle, Last	1)	H	omemaker	18. Mother's Nan	ne (First, Middle, Ma	Home	
Maryland	0 0 0 0 0	Be	Frank M. Pusey	,				Dickerso		
Ē	d 2 should the end Ment 7 le marked treumatic e	ဥ	19a. Informant's Name/Relationship	(Tyne Print)	19h Mai	ling Address (Street		ral Route Number, C		Zin Code) 2.1.0.2.7
Ma	12	9	Sharon Knowles			940 Sneth			dela Spri	
-	of Heelth Item 27		20a. Method of Disposition	(Daughter	20b. Place of Disr	osition (Name of			c. Location - City or	
5	ot of tri if if if		1 Seurial 2 Cremation 3		, ,	matory or other place		. 4, 2006	Direct	on MD
Baltimore,	ortan ortan Injuri		<ul><li>4 ☐ Donation 5 ☐ Other (Special Service Lice)</li><li>21. Signature of Funeral Service Lice</li></ul>			Cemetery Name and Addre		. 4, 2000	Rivert	OII, FID
Ba	permit. Peges 1 s Depertment of He Important; if Item any injury or oth once.		A Excell	``	1	Short Fun	eral Hom	e Delmar, Di	19940	
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ó	death certificate be executed a attending physician end ad for use as tha buriel-trensit		resulting in death) Last		a consequence of):					
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Вох	leath certifics attending ph I for use as t	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		☐Ectopic pregnancy	,		23d. Date of de	•
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P. 0	that the de ed by the detached	چ	9 Unknown					1		
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ပ္မ	hes be	9						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u> </u>	F e g	Completed						performe 1 ☐ Yes 2 ☑		2 No
ita I	Phyelclen: this certific ral director,	Be (	25. Was case referred to medical examiner?					th (Check only one)		
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o L			27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inj (Month, Da	ury 28b. Time ay Yeer) Injury	Wor		28d. Describe how	injury occurred	
S:		cat	2 Accident investigation 3 Suicide 6 Could not be				Yes 2 □ No			
Division of Vital Records,	or Atten iftar deat Director: In by the	Certification;	4 Homicide determined	286. Place of in	jury - At home, farm, s tc. <i>(Specify)</i>	treet, factory, office		28f. Location (Street City or Town, S		ural Houte Number,
C)	pital o		200 Codifice 1000 and a	hveleler: T-#- b	of my kenydadaa	th non-		and due to the	a(a) a a d	-1-1-1
	To the Hospital or At within 24 hours effar of To the Funeral Directorypletely filled in by	edical	29a. Certifier 1. ☐ Certifying Pl (Check only 2. ☐ Medical Example)	hysician: To the best miner: On the basis and manner s	of my knowledge, dea of examination and/or i	nvestigation, in my o	ne, date and place pinion, death occu	, and due to the caus rred at the time, date	e(s) and manner as and place, and due	s stated. to the cause(s)
	To the To the Coorplet	Me	29b. Signature and title of certifier	and mainer s	iatou.	29c. Licens	e number	29d.	Date signed (Mont	h, Dey, Year)
	5 ¥ C 00		NACCO							
	1/2	-	NATION OF THE PROPERTY OF THE	completed source -4	death (Item 92-) (To-	Print)	17-11		C.D. 11	X000
	Va	İ	30. Name and address of person who	S4-W	lype) (Iype) (Iype) الله ( ا	- South	DIVISION	sheet	THE ISA	2006 BURY MD 21504
	Sta	te	31. Date filed (Month, Day, Year)	32. Regist	14 ( 8 rar's Signature		, ,, ,		710	218-4
	Registr		FFR 0 1	2006	en H	hack s				
DIVI	AH 17 Rev 1/20			2000	AND IN					

			For State Registrar	State of M	arylar			nt of H <i>te of L</i>		and M	-	giene Reg. No	UUD	; (	)443	} 4
	Dhusisi		1. Decedent's Name (First, Middle, Las	st)							2. Date of De Month	ath Da	v Y	ear	3. Time of D	)eath
	Physici /Medio		Marie	W.		Lee	,				January				11:50 A	M
	Examir		4a. Facility Name (If not institution, give				4b. City	, Town, or	Location of				. County of I			
			Bradford Oaks Nursing				If I lad	or 1 Vans	Clint If Under:		0.0.		Prince			
	Funeral		5. Social Security Number 6. S 577–09–4703	ex 7.Ag □M 2XDXIF	ge (in yrs. 94	last birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Bird (Month, Da January	th y, Year) 12 1	01.2	. Birthple Countr		_
	Director		Usual Residence of Decedent		<i>7</i> 4		L				Januar y	10, 1	1912		Maryl	and
	yland Nor		10a. State 10b. County		10c. Ci	ty, Town or Lo								10	d. Inside City	Limits
	a-fsl	ctor	Maryland Prince G	eorge's		Oxon Hi	.11								1 □ Yes 2	XX No
	or 28	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of Wha	at Count	ry?	
	23a	al	205 Panorama Drive					20745				US	SA			
ထ္	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28a-1 show other traumatic event, the Medical Evarinational Le rolling and	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Armed Forces? 1 Yes 2 1	,		_	edent of Hi ecify Cubai	spanic Orig n, Mexican Specify:	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)	-	14. Race Black, \ Specify:	White, e		
8	ural',	d b	3√X Widowed 4 □ Divorced	Year or Dates:												
5	"nat	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece	kind of w		luring most	of work	ing	16b. K	ind of Busin	iess/Indu	ustry	
7	withir ene. than	m	Elementary/Secondary (0-12)	College (1-4or	5+)		ager	use remed,	,			Fed	leral Go	ovarn	mont	
р О	filled Hygi other	ပိ	17. Father's Name (First, Middle, Last)			1 1 1 1 1	agei		18. Mothe	r's Name	e (First, Middle,			Sverii	IIIEIIC	
Maryland 21215-0036	lid be fental rked c	To Be	John Richard Ward						01	ivia	Elizabet	h Har	desty			
ary	shou and M and M		19a. Informant's Name/Relationship (	**			-				al Route Numbe	-			Code)	
Š	and 2		Nannie Z. Vermillio	n / Niece		4535	01d S	olomon	s Isla	nd Ro	ad Harwo	od, M	brylanc	d 2	20776	
altimore,	of He		20a. Method of Disposition 1 KBurial 2 ☐ Cremation 3 ☐	Removal from State		Place of Dispo cemetery, crer	sition (Na natory or	ame of other place	9)	[	Date	20c. Lo	ocation - Cit	y or Tow	vn, State	
Ĕ	Pag ment ant: i		'4 □Donation 5 □ Other (Specify		C	edar Hil				2/02/			tland,			
Ball	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 ie any injury or other trau once.		21. Signature of meral Service lacer	lah		22	2. Name a	and Addres	s of Facilit	y Geor	ge P. Kai on Hill, I	las F Varvī	uneral	Home 2074	PA	
			23a. Part1 Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each l	ine.	th. Do not ent	er the mo	de of dying						í	Approximate Interval Betwee Onset and De	
	Physician /Medical		disease or condition resulting in death)	a. CONGEST  Due to (or as	-		AILU	RE						1		
	Examiner	L	Sequentially list conditions,	b												
	ed sit	Examiner	if any, leading to immediate Cause (Disease or injury	Due to (or as	a consec	(uence of):								- 1		
•	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as	a consec	(uence of):								-		
8760,	icate be executed physician and s the burial-transit	dical E		d												
89	ificate phy as the	edlo		0.												
ŏ	h cert anding	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1□Live birth			TE et aprio	oregnancy					23d. Date of	f deliven	у	
Box (	Physician: The law requires that the death certific this certificate has been signed by the attending raid director, page 2 should be detached for use as	by Physician/Me	in the past 12 months? 1 Yes 2XXIII	4☐Pregnant a			Other (s						Month	C	Day Ye	ar
<u>Ч</u>	at the	Phy	9 Unknown													
Division of Vital Records, P.O.	res th		Part II. Other significant conditions of Hypertens:	-		_		-							cause of dea	
orc	w require been sig should t	sted	Try per cents.	ion, nypot	.11 9 1 0	rarbin,	- DCIII		, ,,		-				DIY -ALADIII	KIIOWII
ec	s law has b e 2 sl	Completed									24a. Was autop	SV	prio	r to comp	sy findings av ipletion of cau	railable use of
<u> </u>	: The la cate ha: ; page 2										1 ☐ Yes ∑	rmed? ZZXNo	deat	Yes 2	2□ No	
<u> </u>	ysiclan: Th is certificate director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Othe			(Check anly a					
ō	Phys r this ral di	. To	1 Yes 2 XX	1  Inpati		ER/Outpatien 28b. Time of		UA	4 (2) (2011)	A.P.I.	me 5 Residence 128d. Describe 1			Specify)		
on	ding f th. After funer	tlon	1X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y Year)	Injury	м	28c. Injury Work 1 □ Y	? ′es 2 □ l				,			
/S	of attending after death.  Director: After din by the fune	Certification:	3 Suicide 6 Could not be	28e. Place of In			eet, facto			-	28f. Location (S	Street an	d Number o	or Rural	Route Numbe	8r,
2	after i Dire d in b	ert	4 Homicide	building, et	c. (Speci	(y)					City or Tou	vn, State	)			
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier XX Certifying Ph (Check only one)	ysician: To the best niner: On the basis of and manner st	f examina	owledge, death	occurre vestigatio	d at the tim n, in my op	e, date and inion, deat	d place, th occurr	and due to the ed at the time,	cause(s) date and	and manne I place, and	er as stat due to t	ted. the cause(s)	
	o the	Me	29b. Signature and title of centrier				25	c. License	number			29d. Dat	te signed (M	Aonth, D	lay, Year)	
	1		Kin leading	1 m 1 n	m	10	]	00033	512			Jan	uary 3	30,	2006	
	On U	1	30. Name and address of person who	completed cause of o			Print)									
4	00		Deidra L. Vari	•				on Ro	ad #	203	Ft. Was	shin	gton,	Mar	yland	2074
	Sta	te	31. Date filed (Month, Day, Year)	32. Registr	ar's Signa	ture										
	Registr	ar	JAN 3 1 2006 1	and the	4											

	-	For State Registrar	State of Mary		artment of H rtificate of L		Re	eg. No.	04435
Physicia		Decedent's Name (First, Middle, Last,	Flora Pearl	Lyden			2. Date of Deat Month Februa	Day Year ry 02, 2006	3. Time of Death 5:00 A. M
/Medic		4a. Facility Name (If not institution, give		Lyden	4b. City, Town, or	Location of Deat		4c. County of Dea	
Examin	er		st Railroad Stre	et		Lonace	oning	Al	legany
Funeral		5. Social Security Number 6. Se		n yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth	Year) 9. Bi	thplace (State or Foreign
Director		214-16-2774 Usual Residence of Decedent	8	Yrs.			April 04,	1921	Penńsylvania
š =	-	10a. State 10b. County	10	Oc. City, Town or Lo	ocation				10d. Inside City Limit
f sh ied a	jo	Maryland Alleg	anv		I	onaconing			1. 12 Yes 2 □ No
128a	rec	10e. Street and Number	54119		10f. Zip Code		1	0g. Citizen of What C	ountry?
38 0	o ie	16 West Ra	ailroad Street			21539		U.S	S.A.
E E	Funeral Director	11. Marital Status	12. Was Decedent Eve Armed Forces?	or in U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (S n, Mexican, Puer	pecify Yes or No- to Rican, etc.)	14. Race - Am Black, Wh	
Hygiene. sther than "netural", or Items 23a or 28a-f show ent, the Modical Examinar must be notified at	교	1 Never Married 2 Married	1 Tyes 2 No		1 ☐ Yes 2 ☑ No	Specify:		Specify:	White
ural',	Completed by	3,XWidowed 4 □ Divorced	Year or Dates:	16a Dece	dent's Usual Occupa	ation		16b. Kind of Business	
"nel	Jete	(Specify only highest grad	le completed)	(Give	dent's Usual Occupa kind of work done o DO NOT use retired	furing most of wo	rking		•
iene.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		Но	memaker		Н	ome
Department of Health and Mentat Hygiene. Important, or Items 23a or 28a-f show important: If item 27 is marked other than "netural", or Items 23a or 28a-f show any injury or other traumatic event, the Modical Examination as the notified at 2008.	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Na	me (First, Middle, I		
Menta trked tic e	To B		Arthur Swift					dna Lung	
and Is ma	1 9	19a. Informant's Name/Relationship (T)		19b. Maili				City or Town, State,	
ealth m 27 ner tr		Dianna Muir - I		20h Blace of Disease		estown Stree		ng, Maryland, 2 20c. Location - City o	
iter or oth		20a. Method of Disposition 1 ☐ Burial 2 🗷 Cremation 3 ☐ F		•	matory or other plac		February 05,	C. Alexandra	
tant:		'4 □Donation 5 □Other (Specify)			rland Cremat	- 1	2006		d, Maryland
Importany in		21. Signature of Funeral Service Licens  L. McKen	<i>\( \sqrt{\text{9}} \)</i>			Lonac	oning, Maryl	e P.A., 8 East Nand, 21539	Main Street,
		23a. Part 1. Enter the disease, or comp	lications that ceused the	e death. Do not en	ter the mode of dyin	g, such as cardia	c or respiratory arr	est,	Approximate Interval Between
ysician		Immediate Cause (Final disease or condition	. ( broni	a Obs	brue tu	e /hu	monar	y bisea	Onset and Death
Medical		resulting in death)	Due to (or as a c	onsequence of):			1	1	1
aminer		Sequentially list conditions,	b					·	
sit	ine	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c	ons quence or:					
and I-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a c	consequence of):					
physician and s the burial-transit	dicai E		d						
p phys	0		u						
attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2 [		⊒Ectopic pregnancy			23d. Date of d	
e atte	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at tirr 9☐Unknown		Other (specify)			Month	Day Year
ed by the a detached f	hys	9 Unknown	-				on Bidas	h	to the cause of death?
5 8	þ	Part II. Other significant conditions co	ontobuting to death but r	not resulting in the L	inderlying cause give	en in Parti.	1 12 1		Probably 4 Unknow
been si should I	Completed			· -	····				
2 5	npie			<del></del>			24a. Was a autops	sy prior to	utopsy findings available completion of cause of
ate	S						1 ☐ Yes	2 🗗 No	
is certific director,	Be	25. Was case referred to medical examiner?	Hospital:	-57500	oth Oth	on.	ath Check onl or		
<del>⊆</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del> <del>-</del>	2	1 Yes 2 No	1 L Inpatient 28a. Date of Injury	2 ER/Outpatie	nt 3 DOA	4   Nursing	-	ence 6 □Other (Sp ow injury occurred	өспу)
After funer	tion	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Y	'ear) Injury		k? Yes 2⊡No			
Director: A	Certification	3 Suicide 6 Could not be 4 Homicide determined		- At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Town	itreet and Number or I n, State)	Ru <i>ral R</i> oute Number,
witnin z4 nours arter o To the Funerel Direct completely filled in by		29a. Certifier 1 Certifying Phy	ysician: To the best of a	my knowledge, dea	th occurred at the tir	ne, date and place	e, and due to the c	cause(s) and manner	as stated.
n 24 he Fu pietel	Medical	(Check only 2 Medical Exam	and manner state	d.					
Tot	Σ	29b. Signature and title of certifier	na Roll	1	29c. Licens			29d. Date signed (Mo	
		1 / severly	In Call	Em /	1/) DO	05 44 1		02-02	-2006
5			completed cause of dea		Print) CIA-1 Allen	ne Cun	berland,	Many/An	-2006 221502
Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's		/	,			
Regist		FEB - 3 2	006	w de a	Property D				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** John W 4:35 PM -29-2006 Leiste /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic Beilin Hospita Gereral Worcester If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral<sup>\*</sup> 9. Birthplace (State or Foreign Days Months 1√2 M 2□ F 85 Yrs. Director 579-16-3600 08-10-1920 ASHLAND, PA Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at Director N☐Yes 2 ☐ No WORCESTER OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23s or 167 BEACH COMBER LANE Completed by Funeral 21842 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race · American Indian, Black, White, etc. 1 Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ♥☐ No Specify: Specify: WHITE 3 ♥ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene.
7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) 12 ENGINEER PHONE COMPANY Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be WILLIAM A. LEISTER GRACE L. YOST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a. Important: If Item 27 Is any injury or other trau QDCE. 47 NOTTINGHAM LANE, OCEAN PINES, MARYLAND 21811 GREG LEISTER - SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 02-04-2006 BRENTWOOD, MARYLAND 22. Name and Address of Facility BOUNDS FUNERAL HOME, INC. 21. Signature of Funeral Service Licensels 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused the death. 705 EAST MAIN STREET, SALISBURY, MARYLAND 21804 Approximate Interval Between Onset and Death Immediate Cause (Final Physician tailure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner SC/S)
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury nding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Ne 24a. Was an autopsy performed? Yes 2 No 1□ Yes 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 ☐ Yes 2 ☐ No 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred ision Hospital or Attending 1 Maturai 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deati To the Funeral Director: 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie: (Chock only one) To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) (DE) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KRISTING GRIFFIN MD 1269 CUASTAL HIGHE AY FEMMICK ISLAND, DE 19944 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 1 2006 Registrar

S S S

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	State of Maryland / Department of		
	1 - State Certificate C		ZUUb U443/
Physicia	1. Decedent's Name (First, Middle, Last)  William Wilbert Leatherbury Sr.	2. Date of Death Month	Day Year 3. Time of Death
/Medic Examine		n, or Location of Death	27 206 1840 M 4c. County of Death
**************************************	5. Social Security Number 16. Sex 7. Age (In yrs. last birthday) If Under 1 Ye	ar If Under 24 Hrs. / 8 Date of Right	Wiemie
Funeral Director	220-12-0232 15 Months Day		9 22   9. Birthplace (State or Foreign Country) Maryland
W	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits
idential W. Fether Bull 19-038 ore, Maryland 21215-0036 Ad 17-033 ore, Maryland 21215-0036 Ad 17-033 or 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  Item 27 is marked other than "natural; or items 23s or 28s-1 show other traumatic event, the Medical Exercit at must be notified at	Maryland Wicomico Fruitland  10e. Street and Number 10f. Zip Code		1 X Yes 2 □ No
5-13 in with the	106. Street and Number 213 Poplar Street 218	-3	Citizen of What Country? U.S.A
33	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Manager Forces? 14. Was Decedent of Manager Forces?	of Hispanic Origin? (Specify Yes or No- uban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
OO36 on teal; or item	3 Widowed 4 Divorced If Yes, Give Year or Dates: 14 W 1 1 Yes 2 1 1		Specify: Black
HRACIBA 215-0036 Ithin 72 hours aft 16. 18. 18. "neturel", or in Medical Exerci	15. Decedent's Education 16a. Decedent's Usual Occ	cupation 16b ne during most of working ired)	b. Kind of Business/Industry
2121s de within giene.	Elementary/Secondary (0-12) College (1-4or 5+) Truck Driv	,	Trucking
and be file of other event,	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maid	
laryland 2  2 should be filed v and Mental Hygie is marked other t aumatic event, th	Henry Leatherbury  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Stre	Helen Jpnes eet and Number or Rural Route Number, Cit	ty or Town State Zin Code
William Baltimore, Ma permit. Pages 1 and 2. Department of Health at Important: If Item 27 is any injury or other frau	Marilyn Leatherbury (Wife) 213 Poplar	St.Fruitland,Md	
imore, N Pages 1 and ment of Health aut: If Item 27 ury or other th	20a. Method of Disposition  1 ★Burial 2 □ Cremation 3 □ Removal from State	2././	. Location - City or Town, State
Wellian Baltimore, permit Pages 1 a Department of Hee Important: If Item any injury or othe	4 □ Donation 5 □ Other (Specify) Springhill Mem  21. Signature of Funeral Service Licensee 22. Name and Add	tress of Facility	ebron, Md.
o seesa	Gladys B: Stewart 821 Wes	Funeral Home t Rd.Salisbury,M	d.21801
Physician	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dishock, or heart failure. List only one cause on each line.  Immediate Cause (Final	ying, such as cardiac or respiratory arrest,	Approximate Interval Between Onset and Death
/Medical Examiner	disease or condition resulting in death)  a.   TELTONITIS  Due to (or as a consequence of):		
***	Sequentially list conditions.  b. NTESTINAL PERFORATE  Due to (or as a consequence of):	TON	
D, executed in and ial-transit	cause. Enter Underlying Cause (Disease or injury that indiated events c.		
760, te be executed ysician and te burial-transit			
687 tificate g phys	d		
I Records, P.O. Box 68  The law requires that the de.th ce tilical rate has been signed by the attending phy, page 2 should be detached for use as the contributed by the attending by	23b. Was decedent pregnant   23b. Was decedent pregnant   1 Live birth 2 Fetal death 3 Ectopic pregnant   1 Ves 3 Ne   1 Pregnant at time of death 5 Other (specify)	icy	23d. Date of delivery  Month Day Year
Division of Vital Records, P.O. or or Attending Physician: The law requires that the dealth. Director: After this certificate has been signed by the string the funeral director, page 2 should be detached.	1 Yes 2 No 9 Unknown  4 Pregnant at time of death 5 Other (specify) 9 Unknown		
dS, I	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of CHRANIC RENAL FAILURE		o use contribute to the cause of death?
ecord	RESPIRATORY FAILURE	24a. Was an	2 No 3 Probably 4 Unknown  24b. Were autopsy findings available
II Re		autopsy performed?	? death?
f Vita	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
On of Viding Physis in:  After this of funeral directors	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA C 27. Magner of Death 28a. Date of Injury (Month, Day Year) 1 Natural 5 Pending (Month, Day Year) 1 Injury 28c. Injury	4 Nursing Home 5 Hesidence	
isio ktendi death ctor: A y the fu	2 Accident investigation M 1 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	_Yes 2 □No	
Division c	4 Homicide determined 286. Place of injury - At nome, farm, street, factory, office building, etc. (Specify)	City or Town, Sta	and Number or Rural Route Number, ate)
Hospi 4 hou Funer ely fill	29a. Certifier  (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the examination and/or investigation, in my and manner stated.	time, date and place, and due to the causer opinion, death occurred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)
To the Hos within 24 h within 24 h To the Euro			Date signed (Month, Day, Year)
10x	Mahuhut T MD D-	0060515 1	1/28/06
101	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  M. T. H. M. M. A. A. A. A. A. A. A. A. A. A. A. A. A.	VSHURE DK , SALISBU	LEY AID DIONI
State	31. Date filed (Month, Day, Year) 32. Hegistrar's Signature	THINK UM JACOBL	NI MU 4804
Registrar	FEB 0 1 2006 Brown St. Angelis		

	,		1 - State Registrar		artment of Health and rtificate of Death	Reg. (	<u>~006 04438</u>
	Physici	an	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year 3. Time of Death 5:17 P M
	/Media	al	Marlene McQuiston  4a. Facility Name (If not institution, give street and number	)	4b. City, Town, or Location of De		16, 2006 5:17 P M
	Examin	er	Laurel Regional Hospital	,	Laurel		Prince George's
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday)	If Under 1 Year If Under 24 Hi	s. 8. Date of Birth	
	Director		194-36-7600 1□M 2\\ F	63 Yrs.	Months Days Hours Mi	April 1,	1942 Pennsylvania
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
	Manylan f show	٥	Maryland Prince George's	Laurel			1∭Yes 2 □No
	r 28a-	Director	10e. Street and Number	Laurer	10f. Zip Code	10g.	Citizen of What Country?
	h with	al D	14200 Laurel Park Drive		20707	U.S	S.A.
	ems s	iner	11. Marital Status 12. Was Deceden Armed Forces	Ever in U.S. 13.	Was Decedent of Hispanic Origin?	Specify Yes or No-	14. Race - American Indian, Black, White, etc.
36	or it	y Fu	1 Never Married 2 Married 1 Yes 2 Never Married 2 Married 1 Yes, Give	No	1 ☐ Yes 2 No Specify:	,	Specify: White
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "naturel", or Iteme 23a or 28a-1 show that the Madical Exercitational ternetified at	Completed by Funeral	3 Widowed 4 Divorced Year or Dates:	16a Dece	dent's Usual Occupation	16h	. Kind of Business/Industry
215	zin 72	plet	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or	(Give	kind of work done during most of w DO NOT use retired)	orking	. Table of Bearings and Table 1
212	giene giene er tha	Com	6	n/a		n/	a
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. Item 27 is marked other than "naturel", or Items 23a or 28a-1 show item 27 is marked other than "naturel", or Items 22 or 28a-1 show other traumatic svent, It a Madical Exerciter must be notified at	Be	17. Father's Name (First, Middle, Last) Unknown			ame (First, Middle, Maid	den Surname)
yla	should be fand Mental be smarked of	2			Unknown		
Mar	d 2 sh th and 7 Is n traun	l á		ociui.	ng Address (Street and Number or I		V-1
	permit. Pages 1 and i Department of Health Important: If item 27 any injury or other tr once.		Rubenia Williams-Winston: V	20b. Place of Dispo	sition (Name of		Location · City or Town, State
JOH	Pages nent of I int: If its iry or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify) 3		matory or other place)	25/2006	lexandria, Virginia
Baltimore,	permit. Pages Department of Important: If it any injury or o		21. Signature of Funer / Soppics In ee		2. Name and Address of Facility G		
ä	Depared Important in moon in conce.		+ selette 11 ag/				sville, MD 20781
			23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Do not ent	er the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between
	Pnysician		Immediate Cause (Final disease or condition Pneumon	nia			Onset and Death
	/Medical Examiner			a consequence of):			
		-	Sequentially list conditions, if any leading to immediate	a consequence of):			
	uted 1 ansit	min	causé. Enter Underlying	atory Failu	re		
oʻ	exec an an	Еха		a consequence of):			
8760,	cate be executed oblysician and the burial-transit	lical	d				
Box 68	death certificate be executed e attending physician and od for use as the burial-transit	Physician/Medical Examiner	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant			-	23d. Date of delivery
	death e atte id for	icla	In the past 12 months?  1 ☐ Yes 2 M No. 4 ☐ Pregnant a		Ectopic pregnancy Other (specify)		Month Day Year
P.0	that the de led by the a detached	hys	9 ☐ Unknown				
	es be	by	Part II. Other significant conditions contributing to death	out not resulting in the u	nderlying cause given in Part I.		to use contribute to the cause of death?
ord	w requir been si should	ted	Thrombocytopenia			1 L Yes	2 No 3 Probably 4 Unknown
Vital Records,	has by	Completed	Cerebral Palsy			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?
alF	The ate					1 ☐ Yes 2 🔀	
<u>Sit</u>	Physicien: this certificatal director.	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No Hospital: 1 ☒ Inpati	ent 2 ☐ ER/Outpatier	Other	eath (Check only one)	C COther (Conside)
of		n: To	27. Manner of Death 28a. Date of Inj	ury 28b. Time of		Home 5 Residence 28d. Describe how in	
ion	Attsnding Ph r death. ector: After th by the funeral	atio	1 X Natural 5 ☐ Pending (Month, Di 2 ☐ Accident investigation	ay Year) Injury	M 1 ☐ Yes 2 ☐ No		
Division	₩ O O →	Certification:		jury - At home, farm, str tc. (Specify)	eet, factory, office	28f. Location (Street City or Town, St.	and Number or Rural Route Number, ate)
	urs afte					W	
	Hosp 24 hou Fune Fune	edical	29a. Certifier 1 ⊠ Certifying Physician: To the best (Check only one) 2 ☐ Medical Examiner: On the basis one) and manger s	of examination and/or in	h occurred at the time, date and plan vestigation, in my opinion, death occ	ce, and due to the cause curred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	Mec	29b. Signature and title of certifier		29c. License number	29d. I	Date signed (Month, Day, Year)
	F 5 F 8		1 Daniel Stor		005323	_	19/06
	(1)		30. Name and address of person who completed cause of	death (Item 23a) (Type,		/ //	. ,
_	Je.		Darryl A. Hill, M.D. 13635	Baltimore	Avenue, Laurel,	Maryland 2	0904
	Sta Registr	1		rar's Signature			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg-No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day D. McGinn January 26, 2006 3:28 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cherry Lane Nursing Home Prince George's Laure1 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Y April 13, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕅 F Director 481-16-9026 82 1923 Iowa Usual Residence of Decedent the Maryland 10a. State 10b. Count 10c. City, Town or Location 28a-f show 10d. Inside City Limits Examiner roust be notified at 1 Yes 2 □ No Directo Maryland Prince George's Glenn Dale 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? ŏ 9924 Worrell Avenue or Itema 23a 20769 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. int: If Item 27 Is marked other than "natural", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☒ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Degner Emma Hogrefe 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. McGinn - Son 12147 Dove Circle, Laurel, Maryland 20708 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State ¹ 4 ☐ Donation 5 Other (Specify) Fort Lincoln Cemetery 1/31/2006 Brentwood, Maryland 21. Sign, tur Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disea is or condition resulting in death) Arteriosclerotic Cardiovascular Disease 1 year /Medical Due to (or as a consequence of): Examiner Severa1 Hypertension Sequentially list conditions, Years Examiner cause. Enter Underlying Cause (Disease or injury Directo for as a nonsecuence off The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy j Month Day 4□Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown 2 cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 Probably 4 MUnknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 📉 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No after death 2 Accident the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide filled in within 24 hours 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D24721 January 27, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14333 Laurel Bowie Road #208, Laurel, Maryland 20708-1179 Syed A. Sadiq, M.D. 31. Date filed (Month, Day, Year) 32, Registrar's Signature JAN 3 1 Registrar 2006

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

2. Registrar's Signature

		_	1 - For State Registrar		Marylan		artment rtificate			and M	lental Hygi	ene	06	04441
	Physici	an	Decedent's Name (First, Middle								2, Date of Death Month	Day	Year	3. Time of Death
	/Medi		HUBERT	WALLACE	MOOI	RE					January	29	2006	14:55 M
	Examir	ier	4a. Facility Name (If not institution,		•				Location of	of Death			unty of Death	
			Montgomery Gene  5. Social Security Number		.a.1 Age (In yrs. I	ast hirthday)	If Under 1	lney	If Under :	24 Hrs	9 Data of Righ		ntgome	
	Funeral Director		217-32-4297 Usual Residence of Decedent	1)⊠M 2□F	68	Yrs.		Days	Hours	Min.	8. Date of Birth (Month, Day, March 2	Year) 7 193	37 Wash	place (State or Foreign http:) ington,D.C.
	land ow		10a. State 10b. County		10c. City	, Town or Lo	cation	_					7	10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show finast be redified at	ţo	Md. How	ard	Wo	oodbin	е						į	1 ☐ Yes 2 No
	h the	rec	10e. Street and Number				10f. Zip (	Code			10	g. Citizer	of What Cour	ntry?
	th with	ai D	16076B A. E. I	Mullinix Ro	ad				2179	7		Uni	ted St	ates
	ter deal	Funerai Director	11. Marital Status  1 ☐ Never Married 2 ☑ Marrie	12. Was Deceder Armed Force ad 1 Yes 2	s?	S. 13.	Was Decede f Yes, specif	ent of His fy Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	
21215-0036	72 hours after natural', or Ita ilcal Evantre	by	3 Widowed 4 Divorced	If Yes, Give Year or Dates			1 Yes 2	No No	Specify:			Sp	ecify:	White
2	"natu	iete	15. Decedent (Specify only highes	s Education : grade completed)		(Give	dent's Usual kind of work	done d	lurina most	of worki	ng 1	6b. Kind	of Business/In	dustry
72	withir ene. than	Completed	Elementary/Secondary (0-12)	College (1-4d	or 5+)		<i>00 NOT use</i> hanic	retired)	)			Aut	omotiv	e
	filed Hygi other		17. Father's Name (First, Middle, L						18. Mothe	r's Name	(First, Middle, M	aiden Su	mame)	
Maryland	permit Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itams 23a or 28a-1 show any in ury or other traumatic avant, the Medical Examination at Italian at once.	To Be		Moore					Eth	le1	Roberta	a F	Iolland	
	and 2 st alth and 27 is n er traun		Jeanet Faye Mod				-				i Route Number, oad, Wood	· .		21797
ore	of He of He r oth		20a. Method of Disposition  1 ★ Burial 2 □ Cremation	3 □Removal from Stat	20b. Pl	ace of Dispo	sition (Name	e of ner place	9)	0	ate 2	0c. Locati	ion - City or To	own, State
Ĕ	Pages ment of I ant: If its		`4 □ Donation 5 □ Other (Sp			Union	Cemete	ery	1	2/2/	/06	Rock	ville,	Md.
Baltimore,	permit Depart Import any in		21. Signature of Funeral Service L	Barker		22	Name and Murie P. O.	Address eI H	s of Facility Bar	ber	Funeral Laytons	Home	e. Md.	20882
	Physician /Medical Examiner		23a. Part1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death)	a. Acuke	ed the death line.	adici	er the mode						~	Approximate Interval Between Onset and Death
8760,	ate be executed hysician and the burial-transit	dicai Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	as a consequ	ence of):	Dive	201-L					8	S VOCT
O. Box 6	The law requires that the death certific thas been signed by the attending page 2 should be detached for use as:	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	death 3	Ectopic pred					23d.	Date of delive Month	ery Day Year
JS, P.	signed b	by	Part II. Other significant condition	s contributing to death	but not resu	lting in the ur	iderlying cau	ise give	n in Part I.			cco use o		ne cause of death?
OC	w requir been si should l	etec	A Chemic Cent	710034 C. J. G. 27	14						1 103			ably 4 Unknown
Vital Records,		Completed	Digsete.								24a. Was an autopsy perform		death?	psy findings available inpletion of cause of 2 No
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?							of Death	(Check only one	-		
	Physi r this o	5 To	1 Yes 2 No 27. Manne of Death	Hospital: 1 ☑ Inpa 28a. Date of In		R/Outpatien			4 🗀 14u1		ne 5 Residen			/)
Division of	or Attanding Phater death. Director: After thin by the funeral	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investiga	(Month, E	ay Year)	Injury	M	o. Injury Work' 1 □ Y	es 2□N		od. Describe now	ringary oc	Carred	
DIVIS	al or Att s after de il Directi ed in by t	Certification:	3 Suicide 6 Could not determine	286 Place of I	njury - At hor etc. <i>(Specify)</i>	me, farm, stre	et, factory, o	office		2	8f. Location (Stre City or Town,		umber or Rura	l Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 1 ✓ Certifying (Check only one) 2 ☐ Medical E	Physician: To the bes xaminer: On the basis and manner	of examinati	vledge, death on and/or inv	occurred at estigation, in	the time	e, date and inion, death	place, a	nd due to the cau ed at the time, dat	se(s) and e and pla	l manner as st ce, and due to	ated. the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	111					number	4			gned (Month, I	
	5	-	Cl Ho	elly			0	21.	337		Jo	nuc	4 29	2006
			30 Name and address of person w	ted cause of	death (Item	23a) (Type, F	rove k	21.	Roc	k	Te, no	20	850	
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 1	2006 32 Regis	trar's Signat	enure	while I							

			1 - For AMEND#9perINF2/3/0 State Registrar AMEND#1perMD2/	of Hill Mar 1/06, HW, McCc	yland / Depa	artment of rtificate of	Health and Death	d Mental Hygie	6 U U U	04442
	Physic /Medi		1. Decedent's Name (First, Middle, Last,	KAY	Mack			2. Date of Death Month	Day Year 31-1006	3. Time of Death
	Examir	ner	4a. Facility Name (If not institution, give Renaissance Gardens Ric	derwood Villa		Silver S			4c. County of Death Prince Geo	nge's
	Funeral Director		5. Social Security Number 098-26-4542 6. Security Number 15	XM 2□F	ln yrs. last birthday) 84 Yrs.	If Under 1 Yea Months Days		drs. 8. Date of Birth (Month, Day, Ye June18, 1	921 Ukra	place (State or Foreign Mylnited The Kingdon
	be filed within 72 hours after death with the Maryland nat Hygiene. ad other than "natural", or Itams 23a or 28a-f show avent, the Medical Exart ar must be notified at	Funeral Director	Maryland 10b. County Montgor  10e. Street and Number 3114 Gracefield Re	nery	oc. City, Town or Lo Silver S	pring 10f. Zip Code	904	10g.	Citizen of What Cou United St	.,
9600	hours after deati ural', or Itams 2	by	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Tyes 2 XNo If Yes, Give Year or Dates:		if Yes, sp <i>ec</i> ify Cu 1 □ Yes 2 【XN	ban, Mexican, Pu			white
21215-0036	- 34	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occi kind of work doni DO NOT use retir	ipation e during most of s ed)	working	. B.M.	dustry
Maryland	2 should be filed withir and Mental Hygiene. Is markad other than aumatic avant, Tre M	a	17. Father's Name (First, Middle, Last) Bruce	M	lackay			Name (First, Middle, Maid Ince Kate	den Sumame) Buckwell	
Baltimore, Mar	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injuryor other traumatic as once.		19a. Informant's Name/Relationship (Ty Lesley Lois Mackay 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F '4 ☐ Donation 5 ☐ Other (Specify)	-wife	3114 ( 20b. Place of Dispo	Gracefie sition (Name of	ld Road,	Rural Route Number, Ci #111 Silver Date 200 /31/2006 Al	Spring, I	Maryland2 9 own, State
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licens  Abruel U B  23a. Part1. Enter the disease, or complete	ee  yww.	22 10 44	naId V. 00 Powde	Borgward	lt Funeral H Road Beltsvi	Home, PA	land 20705
	Cate be executed /Medical Examiner the burial-transit	Examiner	shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Either University Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of):	Hea	st )	Slase	and the state of t	Interval Batween Onse) and Beath
O. Box 68760,	death certificate e attending phy: d for use as the	Physician/Medical	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at tim 9 □ Unknown	Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of delive	ery Day Year
rds, P	es the gned be de	by	Part II. Othar significant conditions cor	ntributing to death but n	ot resulting in the u	nderlying cause g	ven in Part I.	23e. Did tobacc	co use contribute to the	ne cause of death?
al Record	The law ate has b page 2 st	Completed						24a. Was an autopsy performed	prior to co	psy findings available mpletion of cause of
ion of Vital	Attanding Physician: I death, actor. After this certifical by the funeral director, p	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death  1 Antural 5 Pending 2 Accident investigation	lospital: 1 ☐ Inpatient 28a. Date of Injury (Month, Day Ye	2 ER/Outpatien 28b. Time of Injury	28c. Inju	her: 4 Nursing	Peath Check onlone  1 Home 5 Residence 28d. Describe how in		v)
=	i gitte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (S	- At home, farm, str Specify)	eet, factory, office		28f. Location (Street City or Town, St	and Number or Rura ate)	l Route Number,
	tha Hospital in 24 hours a tha Funeral E	ledical	29a. Certifier 1 ✓ Certifying Physical Check only one) 1 ✓ Certifying Physical Examination (Check only one)	sician: To the best of m ner: On the basis of ex- and manner stated	amination and/or inv	occurred at the trestigation, in my	ime, date and pla opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner as si and place, and due to	ated. the cause(s)
į	To the Complet	Σ	29h Signature and title of certifier	sittus			43375		Pate signed (Month,	Day, Year)
_				M.D. 3160	Gracefiel	d Road S	Silver Sp	oring, Maryl	/ Land 20904	
	Sta Registr		FEB 0 1 20	06 32 Negistrar's	Signature	well .				

			_ State	State of Maryla		artment of H			COM 10 1	06 04443	
	_		Registrar  1. Decedent's Name (First, Middle, Last)			timouto or t	<u> </u>	2. Date of De		3. Time of Death	
	Physici	an		akamath				Month	Day	Year	
	/Medic		Clifton O'Neil Ma  4a. Facility Name (If not institution, give st			4b. City, Town, or	1 ocation of D				
	Examin	er	Saint Joseph M	edical Cen	ter		Tow		Day   Year     11 = 585   M     4c. County of Death   Baltimore     4c. County of Death   Baltimore     4c. County of Death   Baltimore     4c. County of Death   Baltimore     4c. County   Paltimore     5d. Kind of Business/Industry     4d. Race - American Indian, Black, White, etc.     5pecify: White     16b. Kind of Business/Industry     Railroad     Middle, Maiden Surname     rude Robertson     6 Number, City or Town, State, Zip Code     7 Stown, MD 21740     20c. Location - City or Town, State     6 Williamsport, Maryland     6 Funeral Home, P.A.     Williamsport, MD 21795     Approximate     Interval Between     Onset and Death     DECADES     23d. Date of delivery     Month Day Year     23d. Date of delivery     Month Day Year     24b. Were autopsy findings available     prior to completion of cause of     1		
			Social Security Number     6. Sex	7. Age (in vrs	s. last birthday)	If Under 1 Year	If Under 24	Hrs. 8 Date of Bir	th		
	Funeral Director			M 2□F 7		Months Days	Hours N	Ain. (Month. Da	v. Year)	Country)	
			Usual Residence of Decedent		<u> </u>			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	JJJ	riar y rana	
	/land		10a. State 10b. County	10c. C	ity, Town or Lo	ecation				10d. Inside City Limits	
	Man	ţ	Maryland Washingto	n Ha	gersto	vn.				1 Yes 2 □ No	
	r 28s	rec	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Country?	
	39 o	0	11 West Baltimore	+2		217	40		USA	1	
	deat	Funeral Director		2. Was Decedent Ever in	U.S. 13.	Was Decedent of H	ispanic Origin	? (Specify Yes or No uerto Rican, etc.)	- 14. Rac		
ထ	after or its	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 X Yes 2 No 1.	0577			ueno Rican, etc.)			
င္ထ	within 72 hours after death with the Maryland ene. than "natural", or items 23e or 28e-f ehow ta Madical Exandrat must be multied at	by	3 XWidowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specif	White	
- 2	natur	Completed	15. Decedent's Educ		16a. Dece	dent's Usual Occupa	ation	working			
2	thin thin	ğ	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done of DO NOT use retired	)				
2	er th	Son	10		Cha	auffer					
2	a H oth	Be	17. Father's Name (First, Middle, Last)				18. Mother's	Name (First, Middle	, Maiden Sumar	me)	
<u>×</u>	Menid arke	ပ္	Clifton H. Mackere								
Maryland 21215-0036	nd 2 should be ith and Mental 27 is marked o r treumatic eve		19a. Informant's Name/Relationship (Typ								
	is 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23e or 28e-f ehow other traumatic event, its Mudical Examplest inual its indifficial at		Clifton L. Barnhart			Glenside					
Baltimore,	of H		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ Re	moval from State	cemetery, crei	sition (Name of natory or other plac	e)	Date	20c. Location	- City or Town, State	
Ē	permit. Pages Department of I Important: if ite any injury or of	1.1	4 ☐ Donation 5 ☐ Other (Specify)			n Mem. Pa	rk 02-	-04-2006	William	sport, Maryland	
at	Depart Import eny inj		21. Signature of Funeral Service Lucinos	0/	22	2. Name and Addres	ss of Facility (	osborne Fu	ne <mark>ral</mark> H	lome,P.A.	
_	20 E 9 9		( can 1-	A	42	25 S.Cono	cocheag	gue St. W	lilliams	port,MD 21795	
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	ath. Do not ent	er the mode of dyin	g, such as car	diac or respiratory a	rrest,	Interval Between	
	Physician		Immediate Cause (Final disease or condition	ARTERIOSCI	FROTI	C CORDI	BUASCI	HOP DIC	EACE		
1	/Medical		resulting in death)	Due to (or as a conse		CHIND L	OVENUEL	JEFIX 1713		UPLIFIUE 5	
	Examiner		Sequentially list conditions, b.								
	D ==	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conse	equence of):						
	nd	Examiner	that initiated events C.								
Ö,	e exe ian e urial.	Ä	resulting in death) Last	Due to (or as a conse	equence of):						
8760,	icate be executed physician end s the burial-transit	dical	d.				· · · · · · · · · · · · · · · · · · ·				
9	ndifficing pl	Ved	IF FEMALE:								
Вох	th ce	an/	23b. Was decedent pregnant in the past 12 months?	<li>c. If yes, outcome of pregative for the control of the contro</li>		Ectopic pregnancy					
	e dea he at	SICI	1 ☐ Yes 2 ☐ No	4☐ Pregnant at time of 9☐ Unknown	death 5	Other (specify)				ontin Day 1941	
0	The law requires that the death certifine is that been signed by the attending is page 2 should be detached for use as	Completed by Physician/Me	9 Unknown								
	res tha signed be de	þ	Part II. Other significant conditions cont		sulting in the u	nderlying cause give	en in Part I.				
ב	w requir been si should I	De d	CEREBROVASCULAR A	CCIDENTS				_ 10	Yes 2∐No	370 Probably 4 Unknown	
ပ္မ	has be	ple	DIABETES MELLITUS							prior to completion of cause of	
<u> </u>	ysician: The is certificate hadirector, page	ě	HYPERTENSION					1 Yes	rmed?	death?	
<u> </u>	ician: Th certificete rector, pag	Be (	25. Was case referred to medical examiner?				26. Place of	Death (Check only of	one)		
<b>&gt;</b>	Physic this ce al dire	10	1 ☐ Yes 2 No	spital: 1 Inpatient 2(	ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursir	ng Home 5 ☐ Resi	dence 6 🗀 Oth	her (Specify)	
٥	ng Ph ter th		27. Manner of Death  1. Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injun World	y at k?	28d. Describe	how injury occur	rred	
Division of Vital Records,	Attending Physician: It death. ector: After this certific by the funeral director,	atic	2 Accident investigation				Yes 2 □ No				
.≅	r Atte	tific	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, str	eet, factory, office				ber or Rural Route Number,	
Ω	rs aft si Di ed in	Certification;									
	To the Hospital or Attending I within 24 hours after death. To the Funersi Director: After completely filled in by the funer		(Check only 2 Medical Examin	cian: To the best of my ki	nowledge, deat nation and/or in	h occurred at the tin vestigation, in my o	ne, date and p	lace, and due to the	cause(s) and m	anner as stated. , and due to the cause(s)	
	To the H within 24 To the F complete	Medical	one)	and manner stated.							
	5 <u>1</u> 5 6	-	29b. Signature and title of certifier	In Mo		29c. Licens	e unwoel				
,			1100.011111			D 518	352		2/1/	1006	
211	. (1 , 1		30. Name and address of person who cor	npleted cause of death (Ite	эт 23а) (Туре,	Print)					
H	-4+1		DAVID A. BRINKER		OSLE	DRIVE	TOWSO	N, MARYL	AND 2	1204	
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	A A	nerte					

			1 - For State Registrar	State of	Marylar		artmen tificate			nd M	ental Hyg	iene	6	
	Physic	ian	1. Decedent's Name (First, Middle, L								2. Date of Deat Month	h Day	Year	3. Time of Death
	/Medi	cal	Junior Asbury Mo								January	31, 2	006	2:00 p. M
4	Exami	ner	4a. Facility Name (If not institution, gi	ive street and numb	er)		4b. City,		Location of				y of Death	
			Avalon Manor  5. Social Security Number 6.	Sex 7.	Age /In ure	last birthday)	If Under		ersto		9. Date of Birth		shing	
	Funeral Director		218-24-9114	1120 M 2□F	76	Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day, June 13	Year) 1020	9. Birth	place (State or Foreign intry) y Land
			Usual Residence of Decedent								June 15	, I ) Z )	mary	y Land
	arylar show	_	10a. State 10b. County		10c. Cit	ty, Town or Lo								10d. Inside City Limits
	Ba-f	ecto	Maryland Washin	ngton		Hag	ersto							1 ☐ Yes 2 ☒ No
	ours after death with the Marylan ral', or Items 23a or 28a-f show Examiner must by notified at	Funeral Director	10e. Street and Number National Pike				10f. Zip		7/0		10	og. Citizen of		intry?
	eath	eral	11. Marital Status	12. Was Decede	nt Ever in III	C 12.1	Mac Doord		740	-2/0	-4. V N	US		
<b>'</b> 0	r Iten	F	1 Never Married 2 Married	Armed Force	es?	13. 1	Yes, spec	ify Cubar	, Mexican,	Puerto F	cify Yes or No- Rican, etc.)		ck, White,	can Indian, etc.
8	el', o	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date			☐ Yes 2	<b>№</b> No	Specify:			Specia	y: W	vhite
5-0	within 72 hours after death with the Maryland ene. than "netural", or Items 23a or 28a-f show he Madical Examiner must be matified at	Completed	15. Decedent's 8 (Specify only highest gi			16a. Deced	ent's Usua	Occupa	tion	of working	1	16b. Kind of B	lusiness/In	ndustry
7	ithin and a	ldr.	Elementary/Secondary (0-12)	College (1-4	or 5+)				uring most o	JI WUIKII	ig			
7	be filled within 72 ha stal Hygiene. sd other than "netu event, Ine Madical		8 17. Father's Name (First, Middle, Las	0		body	mech						repa	air
Maryland 21215-0036	d be fi	Be	Millard McCoy	1)							(First, Middle, M ersole	faiden Sumar	ne)	
Ž	should but nd Ment marked	ဥ	19a. Informant's Name/Relationship	(Type Print)		10h Mailin	a Address	(Strot or			Route Number,	City on Town	Chara Ti	- 0- 4-)
Z	nd 2 sho lith and 27 Is m		Grant Ebersole -	,							erstown			•
ē,	is 1 and 2 should of Health and Mer item 27 Is marke other traumatic		20a. Method of Disposition		20b. F	Place of Dispos	sition (Nam	e of				Oc. Location		
			1 ABurial 2 ☐ Cremation 3 [ 3 4 ☐ Donation 5 ☐ Other (Special Control of the Co		110	emetery, cren ntain	•			/3/0			-	Maryland
#	고문문문		21. Signature of Funeral Service Lice		10				1		NICH FU		_	ilary rand
Ö	Departing Department of the service		ZCAMI	Mun	me	4	15 E.	Wil	son B	lvd.	, Hager	stown,	Md.	21740
	Pnysician /Medical Examiner	ner	23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a. Chy Due to (or	as a consequence of a c	uence of):	rthe mode		0	•			»c	Approximate Interval Between Onset and Death
κ 68760,	death certificate be executed e attending physician and id for use as the burial-transit	Medical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	d	as a consequ									
		by Physician/Med	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 Fetel	Ideath 3	Ectopic pre Other (s <i>pe</i>						te of delive inth	ary Day Year
Δ.	The law requires that the ate has been signed by th page 2 should be detache	γP	Part II. Other significant conditions	contributing to death	n but not resu	ulting in the un	derlying ca	use giver	in Part I.		23e. Did toba	acco use cont	ribute to th	ne cause of death?
ğ	quire an sig uld b	ed b					_				1 ☐ Yes	2 □ No	3 <b>⊠</b> Prob	ably 4 Unknown
တ္တ	aw requir s been si 2 should	Completed									24a. Was an	24b. \	Vere auto	psy findings available
æ	The I	Eo									autopsy performe	ad? (	death?	inpletion of cause of 2 ☐ No
<u>ita</u>	ien: rrtifica ctor. p	BeC	25. Was case referred to medical						26. Place of	f Death /	1 Yes 2 Check only one		163	2   NO
<u>&gt;</u>	Physicien: rthis certifica ral director, p	2	examiner? 1 ☐ Yes 2 No	Hospital: 1 🗌 Inpa	utient 2 🗆	ER/Outpatient	3□ D <b>Q</b> A	Other	4 X Nursi	ing Hom	e 5 🗆 Residen	ce 6 □Oth	er (Specify	()
Division of Vital Records,	Attending Pir death. ector: After to by the funera	Certification;	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio		njury Da <i>y Year)</i>	28b. Time of Injury	28 M	c. Injury a Work? 1 🗆 Ye	ut es 2⊡No		3d. Describe how	v injury occurr	ed	
Divis	or Atte after de Directo Jin by th	ertific	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	286. Place of	Injury - At ho etc. (Specify	me, farm, stre	et, factory,	office		28	Bf. Location (Stre City or Town,		er or Rura	l Route Number,
	To the Hospitel or Attending Physicien: The law within 24 hours after death.  To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	edical C	29a. Certifier (Check only one)  1 Certifying Ph	nysician: To the be niner: On the basis and manner	of examinat	wledge, death tion and/or inve	occurred at estigation, i	the time	, date and p	olace, an	id due to the cau d at the time, date	rse(s) and ma e and place, a	nner as stand due to	ated. the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier		•		29c.	License r				. Date signed		Day, Year)
			n	To				05	53	23	0	1/31/	8	-
j/H	-3		30 Name and address of person who	completed cause o	f death (Item	23a) (Type, P	rint) CV	IET		1				31742
	Sta Registr	te ar	31. Date filed (Monte Pay, Year)	32. Piggi	strar's Signat	ture	entes							

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

# No.				
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	1.9	5-3	1	٩,

			1 - State Registrer	Otate of Ivia		rtificate of Dea		Reg.		THE STATE OF THE S
1	Physic	ian	1. Decedent's Name (First, Middle, I	.ast)				Date of Death Month	_	3. Time of Death
	/Med		Nancy Rebecca MY					anuary	30, 2006	11:15 p <sup>M</sup>
	Exami	ner	4a. Facility Name (If not institution, g			4b. City, Town, or Locati	ion of Death		4c. County of Death	
			11505 Greenberr			Hagerst	own		Washin	
	Funeral Director		5. Social Security Number 6. 220–16–2419  Usual Residence of Decedent	Sex 7. Age 1 □ M 2 ️ F	(In yrs. last birthday)	If Under 1 Year If Un- Months Days Hou	der 24 Hrs. 8. [ rs Min. J	Date of Birth Month, Day, You uly 29,	9. Birth <i>Cou</i> 1925 Ma	place <i>(State or Foreign</i> intry) ryland
	land ow		10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits
	with the Maryland a or 28e-f show	tor	Maryland Washi	ngton	Hager	stown				1 ☐ Yes 2 ☒ No
	th the M or 28e-f	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Cou	intry?
	ath w		11505 Greenberr	y Road		2174	40		USA	
Maryland 21215-0036	or Itams	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hispanic f Yes, specify Cuban, Mexi I ☐ Yes 2⊠ No Spec		Yes or No- n, etc.)	14. Race - Ameri Black, White, Specify:	
2-0	72 hours "natural", adical Eng	ted	15. Decedent's	Education	16a. Deced	lent's Usual Occupation		166	o. Kind of Business/Ir	ndustry
21		Completed	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	)	kind of work done during n DO NOT use retired)		p	ublic sch	001
2	led w lygier har th	S	12	1	subs	titute teach			system	
anc	ba fi	Be	17. Father's Name (First, Middle, Las				other's Name (Fir.			
2	hould d Mei mark metic	<sup>L</sup>	Paul Edwin Anth  19a. Informant's Name/Relationship		405 14-77		la Ellen			
S	od 2 s lith an 27 fs		Deborah R. Myer			g Address <i>(Street and Nur</i> 5 Greenberry				
ē,	s 1 ar f Hea item		20a. Method of Disposition	adagnee!		sition (Name of natory or other place)	Date		. Location - City or To	
Baltimore,	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then 'any injury or other treumetic event, the Magnee.		P Burial 2 ☐ Cremation 3 14 ☐ Donation 5 ☐ Other (Spec			en Cemetery	2/6/06			
atti	mit.		21. Signature of Funeral Service Lice			. Name and Address of Fa			NERAL HOME	Maryland
m	Depariming the period of the p		James d.	picer	41	5 E. Wilson				
	Pnysician	20 10	23a. Part1. Enter the disease, or conshock, or heart failure. List only immediate Cause (Final disease or condition	y one cause on each line.	ne death. Do not ente	er the mode of dying, such	as cardiac or res	piratory arrest,		Approximate Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a c	consequence of):	Myrlon	n 6n			3 1/2 years
4	Examiner		Sequentially list conditions.	b						
	ad isit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a d	consequence of):					
•	artificate ba executad ing physician and e as the burial-fransit	xan	that initiated events resulting in death) Last	c Due to (or as a c	consequence of):					
68760,	e ba e siciar burii		· ·	·						
89	ificate g phy as the	Medical		d						
.O. Box	The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tin 9 ☐ Unknown	☐ Fetal death 3 ☐	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ery Day Year
<u>α</u>	res that igned by be deta	by Ph	Part II. Dther significant conditions	contributing to death but r	not resulting in the un	derlying cause given in Pai	rt J. 2	23e. Did tobacc	o use contribute to the	ne cause of death?
rds	equire en sig ould b							1 🗌 Yes	2₽No 3□Prob	ably 4 Unknown
900	law requas been 2 should	Completed					2	4a. Was an	24b. Were auto	psy findings available
æ		mo:					1	autopsy performed	? death?	mpletion of cause of
Vital Records,	Physicien: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?			26. Pla	ace of Death (Che		10 103	20110
of \	Physic this or al dire	P	1 ☐ Yes 2 ☑ No		2 ER/Outpatient	3□ DOA Cther: 4□	Nursing Home	5 Residence	6 ☐Other (Specify	y)
		on	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	(ear) 28b. Time of Injury	28c. Injury at Work?	28d. [	Describe how in	jury occurred	
Sic	ten leat tor: the	icat	2 Accident investigation 3 Suicide 6 Could not be			M 1 ☐ Yes 2				
5	oitel or Attendurs after death	Certification:	4  Homicide determined	building, etc. (			0	ity or Town, St	·	
	To the Hospitel or At within 24 hours after of To the Funerel Direct completely filled in by	Medical	one)	nysicien: To the best of n miner: On the basis of ex and manner stated	amination and/or invi	occurred at the time, date estigation, in my opinion, d	eath occurred at i	ue to the cause the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
ŀ	To To	Σ	29b. Signature and title of certifier	00.1		29c. License numbe		İ	Date signed (Month, i	Day, Year)
F			Muchael	/	~ MA	0416	67		2.1.06	
1,1	12		30. Name and address of person who				/	1/		
7		10	Michael MC( 31. Date filed (Month, Day, Year)	32 Resistrar's	Signature	died Com	nus 1	Pageri,	NWA M	10
	Sta Registr	ie ar	31. Date filed (Month, Day, Year)	2006	E. A					
DHA	MH 17 Rev 1/20	01		Albreisa	- 17 Ap	e de s				

ORIGINAL

		,	1 - For State Registrar	71	f Marylar	nd / Depa	artme	nt of H		and M	ental Hy	giene	111116	0 44	46
		7	1. Decedent's Name (First, Middle	Last)							2. Date of De Month	ath Day	/ Year	3. Time of	Death
NI.	Physici /Medio		LEONA EDWARDS NO	RFOLK							JANUARY			10:00	P M
No.	Examin		4a. Facility Name (If not institution,	give street and nut	m <i>ber)</i>		4b. City	, Town, or	Location	of Death		4c.	County of Dea	ith	
8.		*	MANOR CARE OF SILV	ER SPRING				VER SI					ONTGOMER		
, i	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bin (Month, Da		9. Bir	rthplace (State o	r Foreign
	Director		578-54-0484		94	Yrs.	ļ				4/28/19	11_	NOR	TH CAROLI	NA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Ci	ty, Town or Lo	ocation			-				10d. Inside Ci	ty Limits
	f sho	ō	MARYLAND MONTGO	MERY	S	ILVER SI	PRING							1 🗆 Yes	2√□ No
	the 28s	Director	10e. Street and Number				10f. Z	ip Code				10g. Cit	izen of What C	ountry?	
	3a or	0	2501 MUSGROVE ROA	AD.			2	0904				U	ISA		
	me 2	Funerai	11. Marital Status	12. Was Dec	edent Ever in U	J.S. 13.	Was Dec	edent of H	ispanic Or	igin? (Spe	ecify Yes or No Rican, etc.)	)-	14. Race - Am Black, Whi		
<b>9</b>	or Ite		1 ☐ Never Married 2 ☐ Marri		2 No		1 ☐ Yes	•	Specify:		riloan, sto.,		Specify:	16, 610.	
Maryland 21215-0036	ral'.	d by	3 ☐ Widowed 4 🏠 Divorced	Year or D	ates:									WHITE	
5	within 72 hours after death with the Maryland ane. then "natural", or iteme 23e or 28e-f show fra Madical Exeminar must be indiffied at	Completed	15. Decedent (Specify only highes			16a. Dece (Give	kind of w	ual Occup rork done o use retirec	during mos	st of worki	ng	16b. K	ind of Business	s/industry	
7	within noe. then	m	Elementary/Secondary (0-12)	College (	1-4or 5+)			ING A				FEL	ERAL GOV	FRNMENT	
N D	be filed vital Hygierd other		17. Father's Name (First, Middle, I	.ast)		1	JICHAL	ING A		er's Name	(First, Middle			DIGITAL TO THE PARTY OF THE PAR	
au	d be antal	o Be	WILLIAM HERBERT						T	VA EUG	ENIA ROB	R			
<u> </u>	should ind Men marke umatic	٦ ک	19a, Informant's Name/Relationsh			19b. Maili	ing Addre	ss (Street					r Town, State,	Zip Code)	
	and 2 : ealth ar n 27 le		MARY ROUNDTREE - S	SISTER		321 UI	NIVERS	ITY BI	LVD. W	., API	111; SI	LVER	SPRING M	D 20901	
Baltimore,	- I 0 -		20a. Method of Disposition			Place of Disponent	osition (N	ame of	e)		Date	20c. Lo	ocation - City o	r Town, State	
Ê	Pages nent of nut: If Its		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (St		State	HINGTON	-		1	2/1/2	2006	SUI	TLAND, M	D	
Ħ	Departm Departm Importa eny Inju		21. Signature of Funeral Service I		,,,,,,				ss of Facili				NERAL HO		
m	9 0 E 9		Myselin T. K	lolad			11800	NEW H	AMPSHI	RE AVE	E.; SILVE	R SPF	RING MD 2	0904	
760,	Physician /Medical Examiner	ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to b. PL Cue to	EUMONIA (or as a consecuence of the consecuence of	FUSION Luance of									
.O. Box 68	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the buriat-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	itcome of pregn birth 2 Fet nant at time of nown	afdéath 3l	⊟Ectopic □ Other (	pregnancy specify)	,				23d. Date of de Month		Year
s, P	es that igned b	by PI	Part II. Other significant condition	ns contributing to c	leath but not re	sulting in the I	underlying	cause giv	en in Part	I.				to the cause of d	
ord	w requires to been signed should be	ted	1										1		
I Records,	The ate h page	Completed									24a. Was auto perfo 1 \( \text{Yes}	psy ormed?	prior to death?		available ause of
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				Oth			h (Check only				
ot	o i i o	2	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date	Inpatient 2	28b. Time		JUA	4 4 1	ursing Ho	me 5 Res 28d. Describe		6 ☐Other (Sp	ecify)	
	ting l	ion	1 X Natural 5 ☐ Pendin	g (Mor	nth, Day Year)	Injury	M	28c. Injur Wor	k? Yes 2 □	1No	200. 0000100	now inju	,, 00001.00		
Division	or Attending after death. Director: After in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could	ot be 200 Place	e of fniury - At h	nome, farm, s					28f. Location	(Street ar	nd Number or F	Rural Route Nun	nber,
<u>S</u>	after Oire	ert	4 Homicide determ	build	ling, etc. (Spec	ify)		,,			City or To	wn, State	9)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	edicai C	29a. Certifier 1 Certifyin (Check only 2 Medical	g Physicien: To th Examiner: On the t and mar	e best of my kn casis of examin	owledge, dea ation and/or ii	th occurrenvestigati	ed at the til	me, date a pinion, de	nd place, ath occur	and due to the red at the time.	cause(s , date an	and manner a d place, and du	as stated. ue to the cause(s	s)
	To the within 2 To the complet	Me	29b. Signature and title of certifie	11	/ '		2	9c. Licens	e number			29d. Da	ate signed (Mai	nth, Day, Year)	
	12		· lams	/ 1	ec			D0532	35			1/	30/2006		
			30. Name and address of person	who completed cau	ise of death (Ite	m 23a) (Type	, Print)								
			DARRELL HILL M.D.	13635 BAI		VENUE, I	AUREL	, MD							
*	Sta Regist		31. Date fifed (Month, Day, Year) FEB 0 1	2006	Registrar's Sign	ature	och	9							

			1 - For State Registrar	State of M	aryland		artment rtificate			and Me		iene	6	04447
8	Physic	ian	Decedent's Name (First, Middle, Last     Na DV								Date of Dea     Month	Day	Year	3. Time of Death
	/Medi Examii	cal	MARY GLADYS NE:  4a. Facility Name (If not institution, give	EDY street and number	-)		4b. City.	Town, or	Location o	of Death	JANUAR:	4c. County		1625 M
	E.Adillii	iei	HOMEWOOD AT WILL		,				VILL I		RT			HINGTON
	Funeral Director		212-24-2867	х Эм <b>Ж</b> ЭF <sup>7. А</sup>	ge (In yrs. lasi 96	t birthday) Yrs.	If Under Months	1 Year Days	If Under:	Min.	8. Date of Birth (Month, Day OCT • 10	), 1909	9. Birth	place (State or Foreign ntry) MARYLAND
	/land		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Inside City Limits
	the Marylar 28a-f show	ctor	MARYLAND WASH	INGTON				WI	LLIA	MSPOF	TS			1 ☐ Yes 2 No
	with th	Funeral Director	10e. Street and Number	ZIONII IIO			10f. Zip	Code	21.	705		0g. Citizen of		•
	Teath The 23	eral	16505 VIRGINIA A		t Ever in U.S.	13. \	Was Deced	ent of His		795 gin? (Spec	cify Yes or No-	14 Rac		S.A.
21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be rectified at	٥	1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deceden Armed Forces 1 Yes 2 2 If Yes, Give Year or Dates:			f Yes, spec I ☐ Yes 2		Specify:	, Puerto F	cify Yes or No- Rican, etc.)	Specif	ck, White, V: V	etc. VHITE
5-0	72 ho netur	eted	15. Decedent's Edu (Specify only highest grad	ication le completed)	1	6a. Deced	ient's Usual kind of won DO NOT us	l Occupa k done d	tion u <i>ri</i> ng most	of workin	g	16b. Kind of B	usiness/In	ndustry
121	filed within Hygiene. Ither than	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I		e retired) RMEF					DZ TRY	Y FARM
	illed Hygid other	Be Co	17. Father's Name (First, Middle, Last)				1.7.	u d-ILDI		r's Name	(First, Middle,			LIMU
ylar	12 should be filed within hand Mental Hygiene. 7 is marked other than "raumatic event, the Man	To B	JACOB GRIFFEY NE	EDY					CLAI	RA GE	NEVA H	ALLER		
, Maryland	ss 1 and 2 sho of Health and item 27 is m r other traum		19a. Informant's Name/Relationship (T) ROBERT L. KOUNTZ			511	HODG	ES I			Route Number			
Baltimore,	Pages 1 nent of He int: if iten		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	cem	etery, cren	sition (Naminatory or other	her place			2006	20c. Location - BOON		own, State  O, MARYLAND
Balti	permit. Pages Depertment of Important: If i any injury or once.		21. Signature of Fune al Service Incens	88	-		. Name and				7606 OI BOONSBO	D NATIONAL	ONAL KYLAI	PIKE ND 21713
*	Physician		23a. In n1. Enter the diseate, or complete ock, in heart failure. List the or condition of the condition of	lications that cause ne cause on each	ed the death. I		er the mode						0.15	Approximate Interval Between Onset and Death
W.	/Medical Examiner	_	resulting in death)	b	s a consequen	ice of):	u.e						Y	ws.
8760,	tate be executed obly sician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	s a consequen									
O. Box 6	The law requires that the death certificate be executed to has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal de	ath 3	Ectopic pre						te of delive	ery Day Year
rds, P.	quires that n signed b uld be deta	by	Part II. Other significant conditions co	ntributing to death	but not resultin	ng in the ur	nderlying ca	use give	n in Part I.			pacco use cont es 2/2 No		he cause of death?
Records,	The law require rate has been sin page 2 should b	Completed					<u> </u>				24a. Was a autops perform	ned?	prior to co death?	opsy findings available impletion of cause of
Vital	ician: T certifical rector, p	Be C	25. Was case referred to medical examiner?						26. Place	of Death	(Check only on			
of \	Phys this al di	2	1 Yes 2 No	lospital: 1 Inpati 28a. Date of Inj	ient 2 ER	Outpatien			4 Nul		e 5 Reside			(y)
		tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Da	ay Year)	Injury	M	Sc. Injury Work 1 □ Y	es 2 1		od. Describe no	winjury occur	90	
Division	al or Attendi after death. I Director: A d in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of In building, e	njury - At home etc. <i>(Specify)</i>	, farm, stre	eet, factory,	office		21	Bf. Location (St City or Town	reet and Numb n, State)	er or Rura	al Route Number.
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one) Certifying Phy	sician: To the best per: On the basis and manner s	of examination	dge, death and/or inv	occurred a restigation,	t the time	e, date and inion, deat	d place, ar h occurre	nd due to the ca	ause(s) and ma ate and place,	inner as s and due to	stated. o the cause(s)
	To the I within 2 To the I complet	W	29b. Signature and title of ceptifer				29c.	License	number	6	/	9d. Date signe		,
1.1	1 71		30 Name and address of person who co	ompleted cause of	death (Item 23	a) (Type, I	Print)		1		0 1/2	IN	1	2006 21742
۲	Sta	_	31. Date filed (Morith Cay, Year) FEB 0 2 2	32. Regist	mus (	Man	(4/)	e	()	+ age	18 YOU		ه دل	21142
	Registr	ar	1 40 4 6 2	JUU Burg	un D	· 19	and I							

State of Maryland / Department of Health and Mental Hygiene 11648 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** DELBERT LEE NIDA 0943AM JAN 30 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Veninsula legional medical Cente r If Under 24 Hrs.  $\mathcal{M}_{l}$ WICOMICO Sex Man 2□ F 7. Age (In yrs. last birthday) r 1 Year Days 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** Months Hours Director 71 Yrs. JULY 16, 1934 229-36-8754 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or itams 23a or 28a-f ahor the Medical Examiner must be notified at 1 Yes 2 No Directo DELAWARE SUSSEX **LEWES** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22951 CYPRESS DRIVE 19958 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 🛣 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) FORKLIFT OPERATOR STEEL FABRICATION CO. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be should be f WILLIAM GORDON NIDA BERTHA HELEN SMITH 19a. Informant's Name/Relationship (Type, Print) pormit. Pages 1 and 2
Department of Health an, important: if Item 27 is reary injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA (McMULLIN) NIDA/WIFE 22951 CYPRESS DRIVE, LEWES, DE 19958 20a. Method of Disposition
1 □ Burial 2 ACremation 3 □ Removal from State 20b. Place of Disposition (Name of EASTERN resHORE) ther place) 20c. Location - City or Town, State CREMATORIUM LEWES, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 02/02/06 21. Signature of Funeral Service License M09866 PARSELL AFUNERAL HOMES & CREMATORIUM 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 16961 KINGS HIGHWAY, LEWES, DE 19958 Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) SEPTIC SHOCK Physician 2 WEEKS /Medical Due to (or as a consequence of): Examiner SEPTICE MIA ESCHERICHIA COLI 2 WEEKS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine certificate be executed as the burial-transit Due to (or as a consequence of): physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day ned by the at e detached fo 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 MELLITUS DIABETES 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performe FIBRILLATION ATRIAL 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No ၉ 1 ☑ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funerel Diractor: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 XNaturat 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funerel Dirac 4 ☐ Homicide To the Hospital or 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) du, M.D. D 46962 JANUARY 30, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00. (A)

M. SHIRAZI, M.D. PENINSULA REGIONAL MEDICAL CENTER MD 21081 31. Date filed (Month, Day, Year) 32. istrar's Signature State

DHMH 17 Rev 1/2001

Registrar

FEB 0

2006

239-36-8754

Delbert

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, UU 5 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Robert Edwin Olewine, Sr. February 2006 0710 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 205 River Road E1kton Ceci1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Hours 1**X**M 2□F 165-03-8312 July 29, 1918 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 👿 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 205 River Road 21921 United States 12. Was Decedent Ever in U.S. Acceded Forces? World 1 (X) Yes. 2 □ No If Yes. Give War II Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0wner Retail Furniture 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Miriam Grace Montz

Completed by Funeral Director

George Robert Olewine 19a. Informant's Name/Relationship (Type, Print) Carrie R. Olewine/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 205 River Road, Elkton, Maryland 21921

February

11, 2006

20a, Method of Disposition 1 № Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place) Bethel Cemetery

20c. Location - City or Town, State Chesapeake City, Maryland

21. Sign ture of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line.

Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 Approximate Interval Between Onset and Death

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Immediate Cause (Final

Hy	DOXIA
Due to (	s a consequence of):
Lune	conser
Due to (or a	a consequence of):

Due to (or as a consequence of):

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4☐ Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstraine

1 🗌 Yes 2 🗆 No 24a. Was an

3 Probably 4 □Unknown

Rand Hospital:

autopsy performed?

1 Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

27. Manner of Death

4 Homicide

1 Inpatient 28a. Date of Injury (Month, Day Year)

Other: 2 ER/Outpatient 3 DOA 28b. Time of

4 Nursing Home 5 ¥ Residence 6 □Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

St. Ste 312

29b. Signature

D002135

10 11

within 2 To the

> 31. Date filed (Month, Day, Year) FEB 1 5 2006

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 111 Wiltin W 2. Registrar's Signature

Registrar DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 7; Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "ne any injury or other traumatic event, the Medit once.

filed within 72 hours after death with the Maryland

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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Pinysician

/Medical

physician and the burial-transit

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After

Hospitel n 24 hours a Physician/Medlcal

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other traumatic event, the Medical Exercise Finant be rulified at

Be

Examiner The law requires that the death certificate be executed Records, P.O. Box 68760, of Vital or Attending after death.

Completed Chine Be 25. Was case referred to medical examiner? ို

1 ☐ Yes 2 No Certification:

Natural Accident

5 Pending 3 🗌 Suicide

investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Ellyon

29d. Date signed (Month, Day, Year)

2006

		-	For State Registrar	State of M		d / Depa	rtment o		and Me	ntal Hygi	ene 06	04450
	Physicia /Medic	an	Decedent's Name (First, Middle, Last)     RUKHLYA RAYA ORLOV	SKY						Date of Death Month		3. Time of Death 9:45 A
3. 14	Examin	er	4a. Facility Name (If not institution, give s  CASEY HOUSE  5. Social Security Number 6. Sex	7. A		last birthday)	If Under 1 Y		LLE	Date of Birth	4c. County of Death  MONTG  9. Birth	
SW.	Director		217-94-0193 Usual Residence of Decedent	M 2 1 F	93	Yrs.		ys Hours	S:	EP 1, 1	912 UKRA	INE
	Marylan a-f show	ctor	MD 10b. County MONTGOME	RY	10c. Cit	y, Town or Lo		LLVER S	PRING			10d. Inside City Limits 1 Yes 2 □ No
	th with the 23a or 28	Funeral Director	10e. Street and Number 12309 FEATHERWOOD	DRIVE #4	44		10f. Zip Cod	20904			g. Citizen of What Cou	.S.A.
36	be filed within 72 hours after death with the Maryland ital Hygiene. id other than "returel", or iteme 23a or 28a-f show event, the Madical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 MWidowed 4 Divorced	12. Was Deceder Armed Forces 1 ☐ Yes 2 ∑ If Yes, Give Year or Dates	s? ₫No	1	Was Decedent f Yes, specify ( 1 ☐ Yes 2🎇	ol Hispanic Ori Cuban, Mexica No Specify:		ify Yes or No- can, etc.)	14. Race - Amer Black, White Specify:	
215-0	ithin 72 hounder.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation completed) College (1-4o	r 5+)	16a. Dece (Give life.		one during mos stired)	st of working	7	6b. Kind of Business/l	ndustry
Maryland 21215-0036	e filed Il Hygiv other	Be	12 17. Father's Name (First, Middle, Last) TTZHAK REZNIK				HOME		er's Name (		OWN HOME	
Mary	nd 2 should the and Me 11 smark	오	19a. Informant's Name/Relationship (Ty, JANE FURMAN/DAUGHT					reet and Numb	er or Rural	Route Number,	City or Town, State, Z	
Baltimore,	i. Pages 1 and 2 should b thent of Health and Ments reart: if item 27 is marked lyury or other traumatic e		20a. Method of Disposition  1  □ Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from Stat		cemetery, crei	sition (Name of natory or other	place)	Da		Oc. Location - City or DELPHI, MA	
Balti	permit. Departrr importe eny inju		21. Signature of Fun ral Signa	)	,	D <i>A</i>	NZANSK 70 ROCI	KVILLE	ERG M PIKE	ROCKVI	CHAPELS, LLE, MARYL	INC . AND 20852 Approximate
760,	Physician /Medical Examiner is pruja-itausi	cai Examiner	23a art1. Enter the disease, or complishook, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that infitiated events resulting in death) Last	ADVANCI Due to (or a	ED PAN	ICREAT] quence of): quante of).						Interval Between Onset and Death
.O. Box 687	deeth certifica e attending ph ed for use as th	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yas 2 ☒ No 9 □ Unknown	3c. If yes, outcon 1 ☐ Live birth 4 ☐ Pregnant 9 ☐ Unknown	2 ☐ Feta at time of c	al death 3	□Ectopic pregr □ Other (s <i>pecit</i>				23d. Date of deli Month	very Day Year
<u>α</u>	uires that t signed by lid be deta	ρ	Part II. Other significant conditions con	ntributing to death	but not res	sulting in the u	nderlying caus	e given in Part	l.	1	acco use contribute to s 2 XNo 3 ☐ Pr	the cause of death?
Vital Records,	The law requires that the sete has been signed by the page 2 should be detache	Completed								24a. Was ar autops perform 1 Yes 2	y prior to o	topsy findings available completion of cause of
Vita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	lospital:		15010		0.11		(Check only one		LUCCRICE
of	<b>2</b>	ation: To	1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	1 ∐ Inpa 28a. Date ol li (Month, i		ER/Outpatie 28b. Time o Injury		Injury at Work?	21		nce 6 XOther (Spec w injury occurred	chy) HOSPIGE
Division	≥ = = c	Certification:	3 Suicide 6 Could not be 4 Homicide determined		Injury - At h etc. (Speci		reet, factory, of	fice	2	8f. Location (Sti City or Town	reet and Number or Ru , State)	ural Route Number,
	To the Hospital or within 24 hours affer To the Funerel Dir completely filled in	Medicai			s of examin						ate and place, and due	
	To the within To the complete	Me	29b. Signature and title of certifier	$\sim$	^	~I)	-	cense number 35635			ANUARY 27,	
	•		30. Name and address of person to co					ROCKVII	LE. M	ARYLAND	20855	
	Sta Regist		31. Date filed (Month, Day, Year)	32. Regi	istrar's Sign	ature	oute					

		•	1- State of Maryland / Dep Registrar Ce	artment of Health and Nertificate of Death		iene g. No. 2006	04451
	* E32		Decedent's Name (First, Middle, Last)		2. Date of Deat Month	h Day Yeer	3. Time of Death
- 61	Physicia		Harry Austin O'Brien		February		12:35 A M
200	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dear	th
100			Avalon Manor	Hagerstown		Washing	ton County
2	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year	8. Date of Birth (Month, Day,	Year) Co	thplace (State or Foreign buntry)
	Director		217-10-2734		Nov 2	1915 Mar	ryland
	land land		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	Many -1 sh	ţ	Maryland Washington Hager	stown			1 XYes 2 □ No
	r 28e	Director	10e. Street and Number	10f. Zip Code	11	0g. Citizen of What Co	ountry?
	23a o	a D	907 View Street	21742		U.S.	
	r dea	Iner	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (S) If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No- p Rican, etc.)	14. Race - Ame Black, Whit	
36	within 72 hours after death with the Maryland ene than "natural", or items 23a or 28e-f show ha Madical Evarues Fries Coulding a	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Mes 2 ☐ No If Yes, Give	1 ☐ Yes XXNo Specify:		Specify: W	hite
Ö	hour:	q pa	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Dece	edent's Usual Occupation		16b. Kind of Business	/Industry
7	in 72	olet	(Specify only highest grade completed) (Give	e kind of work done during most of work DO NOT use retired)	king		
7	with jiene r the	Completed	Elementary/Secondary (0-12) Cottege (1-4or 5+)	Machinist		Truck Mf	g <b>.</b>
פ	e filec of the vent,	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, M		
lar	uld b Wents rked	To	John A. O'Brien		lah McBr	1811	
Maryland 21215-0036	2 sho and I s ma			ling Address (Street and Number or Ru			Zip Code)
≥,	and ealth m 27			View St. Hagersto		Land 21/42 20c. Location - City or	Town, State
Ore	ges 1 t of H If ite or otl		1 XBuriai 2 Cremation 3 Removal from State	omatory or other place) on Memorial Pk. 2-		•	wn Maryland
Baltimore,	t. Pa rtman rtant:		4 Donation 5 Other (Specify)	22. Name and Address of Facility D		_	
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any Injury or other traumatic avent, the Medical Exameral into the collined at once.	) I	Menys A. Tury	1331 Eastern Blvd	. N. Hage	erstown Ma	ryland 21742
-			23a. Part1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Finat disease or condition Dementia	٠			
н	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	1011000 1 1 1 801	lad de		
	Examiner	_	Sequentially list conditions, if any leading to immediate  b. Due to (or as a consequence of):	c covincey vanu	yw or	ocuse	
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury				
	cate be executed physician and the burial-transit	xar	that initiated events c.  resulting in death) Last Due to (or as a consequence of):				
8760,	e be crisician	dical					
9	ifficat ig phy as the	ledi	= = = = = = = = = = = = = = = = = = = =				
Вох	death certific e attending p od for use as	an/N	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 3	☐Ectopic pregnancy		23d. Date of de Month	Day Year
Э.	0 0 0	sicla	1 Yes 2 No gillaknown	Other (specify)			<b>,</b>
P. O.	requires that the death been signed by the atter hould be detached for L	Physiclan/Me	9 ☐ Unknown  Part II, Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I	23e. Did tol	pacco use contribute t	o the cause of death?
Ś	iw requires that s been signed t s should be det	by	Atwal Fibrillation	and any my occording to the control of the control	1 🗆 Y	es 2 No 3 P	robably 4 Unknown
Ö	requ	Completed			24a. Was a	n 24h Were a	utopsy findings available
3ec	e la has	mpt			autops	med? prior to death?	completion of cause of
a				OO Black of Day	1 ☐ Yes :		s 2 No
ξ		Be	25. Was case referred to medical examiner?  1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatie	Othor		ence 6 ☐Other (Spe	ecify)
o	Phys er this eral dii	n: To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at		ow injury occurred	
ion	Attending or death.	atlo	1	M 1 ☐ Yes 2 ☐ No			
Division of Vital Record	Atts er deg recto	Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Si City or Town	treet and Number or Fi n, State)	lural Route Number,
Ö	rs after ral Dire	Cer					
	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di	edical	29a. Certifier  1 ☐ Certifying Physician: To the best of my knowledge, dea (Check only one)  1 ☐ Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place investigation, in my opinion, death occu	e, and due to the curred at the time, d	ause(s) and manner a ate and place, and du	is stated. e to the cause(s)
	To the I within 2 To the I complet	Me	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	ith, Day, Year)
)			•	20062223		2/1/06	
5	SH 10+1		30. Name and address of person into completed cause of death (Item 23a) (Type PLAVECN BILANUM, HD, 30)  31. Date filed (Month, Day, Year)  FEB 0 3 2006  32. Registrar's Signature	B, Print) LED-MILL STREET	HAG(e)	TOWN, MD	
	Sta Regist		31. Date filed (Month, Day, Year)  32. Registrar's Signature	houses			
	riegist	12.1	LE VU LUUU KARKER KA K	Charles and			

		•	For State Registrar	State of Maryla		artment of H tificate of L			giene Reg. No. 0	) 6	04452
7.1	Physici		Decedent's Name (First, Middle, Last)	Eugene	Pressor	1		2. Date of De Month Februa	ath ry 8	<sup>Year</sup> 2006	3. Time of Death 1720 P M
	/Medic Examin		4a. Facility Name (If not institution, give st 1021 Circle Drive			4b. City, Town, or Keymar			Carr	y of Death	
	Funeral Director		442-14-0024		s. last birthday) 32 Yrs.	If Under 1 Year Months Days	Il Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 6	y, Year) 1923	9. Birthp Coun OKla	lace (State or Foreign try) homa
A COLUMN	r 28a-f ehow	irector	Usual Residence of Decedent  10a. State  10b. County  Maryland  Carroll (  10e. Street and Number		City, Town or Lo	10f. Zip Code			10g. Citizen of	What Coun	•
5-0036	u within 72 flours area death with the wasyan jiene. Then "naturel", or flems 23a or 28a-f ehow the Madical Examiner must be natified at	by Funeral Director	1021 Circle Drive  11. Marital Status  1  Never Married 2 Married  3 XWidowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WW		21757 Was Decedent of Hi f Yes, specify Cuba 1 □ Yes 2X No	spanic Origin? (S n, Mexican, Puert Specify:		Bla	States ack, White, afy: Whi	ean Indian, etc.
121	r then	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occupa kind of work done of DD NDT use retired emiployed	furing most of wor ) Masor!		16b. Kind of E	ry	dustry
73	r and 2 should be lined. I Health and Mental Hygis Item 27 is marked other other traumatic event, II	To Be (	17. Father's Name (First, Middle, Last) Eldon R. Presson					ne (First, Middle, ariette S			
Mary	ith and N		19a. Informant's Name/Relationship (Type Rhonda Newton / da			ng Address (Street a Circle Dr		iral Route Numb Keymar,			
imo			20a. Method of Disposition  1X Burial 2 ☐ Cremation 3 X Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	0.0.F.	natory or other place Cemetery	reb	Date . 16 2006	Noble,	Okla	
Balt	Department of Important: If eny injury or once.		21. Signature of Fugeral Service Licenses	un	1	Name and Address 36 East E	Baltimore	e Street	Taney		Md. 21787
60, <	hysician hysician and hysician and hysician and hysician and hysician and hysician and hysician hysician hysician hybridian hy	edicai Examiner	23a. Part1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence of):	ROID	g, such as cardia	A	11634,		Approximate Interval Between Onset and Death
Box 6	e ettending p	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of	etal death 3	⊒Ectopic pregnancy ] Other (s <i>pecify)</i>				ate of delive	ery Day Year
	signed by	by	Part II. Other significant conditions conf	ributing to death but not	resulting in the u	nderlying cause give	en in Part I.		obacco use cor Yes 2 □ No	ntribute to th	he cause of death?
	ine law requiles inet ine ate has been signed by th page 2 should be detache	Completed						24a. Was auto perfo 1 🗆 Yes		prior to co	opsy findings available impletion of cause of
f Vita	rnysician: this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	ospital: 1 🗌 Inpatient 2	! □ ER/Outpatier	nt 3 DOA	or	ath <i>Check only</i> Home 5 X Resi		ther (Specil	(y)
	Attending Fr is death. ector: After th by the funeral		27. Manner of Death 1 X Natural 2 ☐ Accident  5 ☐ Pending investigation	28a. Date of Injury (Month, Day Year	28b. Time o Injury	Worl	yat k? Yes 2 □ No	28d. Describe	how injury occu	ırred	
5	after des	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Spe	t home, larm, str ecify)	reet, lactory, office		28f. Location ( City or To		iber or Rura	al Route Number,
	vithin 24 hours after de To the Funeral Direct completely filled in by the	edical C	29a. Certifier 1X Certifying Phys (Check only one) 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, deat sination and/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occi	e, and due to the urred at the time,	cause(s) and n date and place	nanner as s , and due to	tated. o the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier	Kult	MI	29c. Licens	number 353	18	29d. Date sign	ed (Month,	Day, Year)
	かれ		30. Name and address of person who con	5555a	+n Cei	Her Stree	+ WEST	miuster	MD	2115	)
	Sta Regist		31. Date liled (Month, Day, Year) FEB 1 5 2006	32. Registrar's Si	onature	le de la company					

State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month MARLOW rickles JR 1342 01 OL. 25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F 48 Director 216-78-1203 24, Dec. Maryland Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or Items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2 🔯 No Director Maryland Prince George's Temple Hills 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5733 Middleton Lane 20748 U.S.A. filed within 72 hours after death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry MD National Capitol Park other than Elementary/Secondary (0-12) College (1-4or 5+) Leisure Skills Program Director & Planning Commission 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be fit iment of Health and Mental Hitant; If item 27 Is marked oft Marlon William Pickles, Sr. Patricia Ann Wacker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah J. Pickles - Wife 5733 Middleton Lane, Temple Hills, MD 20748 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. \* 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery Jan. 28, 2006 Brentwood, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Avenue, Hyattsville, MD 20781 ton 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SE **Physician** PSIS /Medical Due to (or as a consequence of): **Examiner** stage Renal chialysis Sequentially list conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed as the burial-transit Diabele Due to (or as a consequence of): attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) 4 Pregnant at time of death the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? this certificate PO No 1 Yes 2 No 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical the funeral director 26. Place of Death (Check only one) Hospital: Other: Inpatient 1 ☐ Yes 2 ☐ No Certification: To 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. injury at Work? 28d. Describe how injury occurred After 5 Pending investigation Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 🔲 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 26/06 8 Sarraray )48042 Chammad 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCKVIlle MD ZOSSZ 5810 Sarrarasi ohammac 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 3 1 2006

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of	Maryland / Depa	artment of rtificate o		and Me		iene 006	04454
	Physici	an	Decedent's Name (First, Middle, Last)	)					2. Date of Deat Month	h Day Year	3. Time of Death
	/Media		ROSALINE ISABELL			Т			January	24, 2006	5:21 a M
	Examir	ier	4a. Facility Name (If not institution, give		•	4b. City, Town		of Death		4c. County of Dea	
			Prince George's  5. Social Security Number 6. Se			Cheve 1	4	24 Hrs. I	0.00	Prince (	
	Funeral Director			x ]M 2ĎŽF   ′.	. Age (In yrs. last birthday) 84 Yrs.	Months Day		Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	rthplace (State or Foreign ountry)
			Usual Residence of Decedent		04	l			April 18	6, 1921   Gur	yana
	yland Now		10a. State 10b. County		10c. City, Town or Lo	ocation					10d. Inside City Limits
	Man Hed	ģ	Maryland Prince G	enroe's	Colmar M	anor					1 X Yes 2 □ No
	n the	Director	10e. Street and Number	00160 0		10f. Zip Code	9		11	0g. Citizen of What C	ountry?
	th wit		3300 40th Place			20722	)		1	U.S.A.	
	dea	Funeral	11. Marital Status	12. Was Decede	ent Ever in U.S. 13.	Was Decedent of If Yes, specify Co		gin? (Spec		14. Race - Am	
98	or It	豆	1 Never Married 2 Married	1 Tes 2	RT No	1 □ Yes 2 🛣 N		, 1 40110 11	ioan, oto.)	Specify: D	
g	72 hours after death with the Maryland 'natural', or items 23s or 28s-f show dical Evantiner must be nutflied at	d by	3 X Widowed 4 □ Divorced	Year or Date	es:					В	lack
5	"nat	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occ kind of work dor DO NOT use reti	ne durina most	of working	g	16b. Kind of Business	s/Industry
2	withii ene. than	m d	Elementary/Secondary (0-12)	College (1-4	or 5+)		1190)			D	
9	filed Hygi other ent, I		17. Father's Name (First, Middle, Last)		Seams	stress	18. Mothe	r's Name (	(First, Middle, M	Private B	usiness
an	ld be ental ked c	To Be	Charles Alexander	Agard			Caro	lina	Vickeri	i e	
Maryland 21215-0036	shoul nd Mi mari	۳	19a. Informant's Name/Relationship (T)		19b. Mailir	ng Address (Stre				City or Town, State,	Zip Code)
Š	nd 2 lith a 27 is r trau		Gloria P. McPhers	ion – Da						. Marylan	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is merked other than "natural", or flems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ance.		20a. Method of Disposition		20b. Place of Dispo			Da	te :	20c. Location - City or	Town, State
Ē	Page nent c int: If		1 XBurial /2 ☐ Cremation 3 ☐ F  1 4 ☐ Donation 5 ☐ Other (Specify)	Removal from St	Fort Linco	-		1/28/	2006	Brentwood,	Manueland
alti	permit. Departn Imports any inju		21. Signature of Funeral Service Licens	<b>Q</b> e	22	2. Name and Add	dress of Facility	Gasc	h's Fun	eral Home	. P.A.
Ω	89589		Ven L. Techeel	2		739 Bal	timore	Ave.	, Hyatt	sville, M	0 20781
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only of	ications that cau	sed the death. Do not ent	er the mode of d	lying, such as	cardiac or	respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Sata		ac ar	rhest	ini	N		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or	as a consequence of):		0				
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	be #	Examiner	Sequentially list conditions, I any leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequence of:						
_	and and I-tran	хап	that initiated events resulting in death) Last	Due to (or	as a consequence of):						
8760,	death certificate be executed e attending physician and ed for use as the burial-transit	dicai E									
687	ficate physics fine	edic		d							
Вох	eath certific attending p	/W	IF FEMALE: 23b. Was decedent pregnant 2	3c. If yes, outco	me of pregnancy					23d. Date of de	livery
	death a atte d for	iciai	in the past 12 months?	4 Pregnan	t at time of death 5	]Ectopic pregnar ] Other (specify)				Month	Day Year
o.	t the by the ache	Physician/Me	9 Unknown	9∐ Unknow	n						
ď.	The law requires that the de ste has been signed by the a page 2 should be detached f	ру Р	Part II. Other significant conditions con	ntributing to deat	th but not resulting in the u	nderlying cause	given in Part I.		23e. Did tob	acco use contribute t	o the cause of death?
ğ	w require been sig should b								1 ☐ Ye	s 2□No 3□P	robably 4 🗹 nknown
Records,	taw re as be 2 sho	Completed							24a. Was ar	24b. Were a	utopsy findings available completion of cause of
	The ate h page	Com							perform	ned? death?	
ita	Physician: r this certifice ral director, I	Be (	25. Was case referred to medical examiner?				26. Place	of Death (	Check only one	9)	
$\leq$	hyei this c	္	1 ☐ Yes 2 ☐ No		atient 2 ER/Outpatien	3 DOA				nce 6 Other (Spe	ecify)
n O	After unera	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of (Month,	Injury 28b. Time of Day Year) Injury	W	/ork?		d. Describe ho	w injury occurred	
Sic	Attending or death. ector: After by the fune	icat	2 Accident investigation 3 Suicide 6 Could not be	20 - Dia	taives At home for		Yes 2 N		M I anation (Ca	446	
Division of Vital	after Direction by	Certification:	4 Homicide determined	building	Injury - At home, farm, str , etc. (Specify)	өөт, тастогу, опіс	ee	20	City or Town	reet and Number or R , State)	urai Houte Number,
	Hospital		29a. Certifier 1∑ Certifying Phys	sician: To the be	est of my knowledge, death	occurred at the	time date and	d place, an	id due to the ca	use(s) and manner a	s stated
	e Ho: 124 h e Fur letely	edicai	(Check only 2 Medical Examinations)	ner: On the basi and manner	s of examination and/or in	vestigation, in my	y opinion, deat	h occurred	at the time, da	ate and place, and du	e to the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Me	29b. Signature and title of certifier			29c. Lice	nse number		29	9d. Date signed (Mon	th, Day, Year)
	(i)		> //n	ett	mo	D5	895	7		01-24-	.06
i	CVE		30. Name and ress of person to co	mpleted cause				0			3 -
_	J. C.		DR GARY WITTLE		3001 HOSPITAL	- DR		CHEV	ERLY,	01-24- MD 201	X5
	Sta		JAN 3 1 2006	"	istrar's Signature				F	-,	
	Registr	वा	JAN 3 1 2006	die .	& hand .						

			-	State of Mary				•		egible.	
			1 - For State Registrar			rtificate of			Reg. No.	006	04455
	Physic	ian	1. Decedent's Name (First, Middle, Las. Burl J. Phillips	0				2. Date of De Month	Day	Year	3. Time of Death 22:32
	/Medi Examii		4a. Facility Name (If not institution, give	street and number)	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, o	or Location of Death	Januar		2006 County of Death	
	LXaiiiii	161	Union Hospital of		tv	E1kton				cil	
	Funeral		5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Year Months Days		8. Date of Bir (Month, Da	rth		nplace (State or Foreign untry)
	Director		Usual Residence of Decedent	A 02	2 115.			May 10	,1923	West	Virginia
	ryland thow		10a. State 10b. County	100	City, Town or Lo	cation					10d. Inside City Limits
	Ba-f s	ecto	Maryland Cecil	No	orth East			- E		.,	1 ☐ Yes 2X No
	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "naturel", or Items 23e or 28a-f show other treumatic event, Itia Mudical Examinat must be notified at	Funeral Director	10e. Street and Number 918 Mechanics Val	lev Road		10f. Zip Code 21901				en of What Co. d State	•
	death	nera	11. Marital Status	12. Was Decedent Ever		Was Decedent of I	Hispanic Origin? (S an, Mexican, Puert			4. Race - Amer	ican Indian,
98	or Ite	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No 1 If Yes, Give	943-	r Yes, specify Cub 1 □ Yes 2 2 No		o Hican, etc.)		Black, White Specify:Whi	
9	hours turel',	ed by	3 Widowed 4 Divorced	rear or Dates: L	340						
Maryland 21215-0036	n "na Nedic	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	de completed)	(Give	kind of work done  DO NOT use retire	pation during most of wor d)	king	160. Kin	d of Business/I	naustry
212	filed with Hygiene. Ither than	Com	11	College (1-4or 5+)	Assem	bly Lin	e Worker		Auto	motive	
<u>n</u>	be file	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne <i>(First, Middle</i> L. Mill		lumame)	
2	2 should be f and Mental H Is marked ot reumatic ever	2	John O. Phillips  19a. Informant's Name/Relationship (T)	una Print)	10h Mailie	an Address (Street	and Number or Ru			Taura Ctata 7	in Code)
	and 2 sealth an n 27 is	i l	Barbara B. Graybea								
Baltimore,	ss 1 and 2 of Health item 27 I		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of		Date	20c. Loc	ation - City or T	own, State
Ĕ	nit. Pages artment of h ortent: If ite injury or of		1 X Burial 2 ☐ femation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	N	<sup>сететету, стет</sup> orth Eas Cemet	t Method erv	ist Febru	ary 1,	Nort	n East	, Maryland
Salt	pernit. Pag Department Importent: any injury o	1	21. Signature of Furnanti Service Learning		22	. Name and Addre	ss of Facility Cr				
	40240		23a. Part 1. Enter the disease, comp	lications that caused the						ist, Ma	ryland 2190 Approximate
	Physician	s i	shock, or heart failure. List only o	ne cause on each line.	A		3650				Interval Between
	/Medical		disease or condition resulting in death)	a. Acul  Due to (or as a cor  Aller	sequence of:	eurouas	regare	lion			Unknown Unknown Unknown
	Examiner	L	Sequentially list conditions,	Alker	oscleno	tic Hear	rt disa	se			tinknus
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cor	isequence oi): Umoni						Untone
ó	te be executed ysician and e burial-transit		resulting in death) Last	Due to (or as a cor		· ·					Chicago
3760,	\$ 5 e	Ical		d					_		
x 68	The law requires that the death certificat ite has been signed by the attending phy age 2 should be detached for use as the	/Med	IF FEMALE:	23c. If yes, outcome of pre							
Вох	atten atten	Physician/M	in the past 12 months?	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time	Fetal death 3	Ectopic pregnancy Other (specify)	/		23	ld. Date of deliv Month	rery Day Year
o.	that the de ned by the a detached	hysi	1 Yes 2 No 9 Unknown	9□ Unknown							
S, D	es tha igned be de	þ	Part II. Other significant conditions co.				en in Part I.				the cause of death?
ord	w requir been si should	eted	Peripheral l	uscular a	riseas	e		1	Yes 2	No 3 Pro	bably 4 □Unknown
of Vital Records,	has by	Completed						24a. Was autor			opsy findings available ompletion of cause of
<u>ra</u>		e Co	25. Was case referred to medical					1 Yes	2 No	1 ☐ Yes	2 No
$\equiv$	Physicien: this certific ral director,	0 8	examiner?	Hospital:	2 ☐ ER/Outpatien	t 3□ DOA Oth	26. Place of Dea	tn <i>(Check</i> on <i>ly c</i> ome 5 ☐ Resi		Other (Speci	fv)
0		n: T	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injur	y at	28d. Describe			
Sio	e ta :- e	catle	2 Accident investigation 3 Suicide 6 Could not be			M 1	Yes 2 □ No				
Division	or Attenater deat Director: in by the	ertification;	4 Homicide determined	28e. Place of Injury - / building, etc. (Sp	At home, farm, stre pecify)	eet, factory, office		28f. Location (3 City or To		Number or Rur	al Route Number,
_	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: Attecompletely filled in by the fune	O	29a. Certifier 1 Certifying Phy	sician: To the best of my	knowledge, death	occurred at the tir	ne, date and place,	and due to the	cause(s) a	nd manner as :	stated.
	he Ho in 24 t he Fu pletely	edical	(Check only 2 Medical Exami	ner: On the basis of exam and manner stated.	nination and/or inv	estigation, in my o	pinion, death occur	red at the time.	date and p	lace, and due t	o the cause(s)
	To T com	Σ	29b. Signature and title of certifier	n.x		29c. Licens	e number	,	29d. Date	signed (Month,	Day, Year)
			) Jackdens		Itom 22a) /T	JO O	しょううと	_		11 50.	06,
-	THIVA		30. Name and address of person who co	$\mathcal{ND}$ , 1/8	North	St Suit	02332: 3B, E	Elkta	n M	1219:	21.
	Sta	- 3	31. Date filed (Month, Day, Year)	32. Registrar's S	ignature						
	Registr	ar	FEB 1 2006	Walles IS	MARKE						

				partment of Health and Mertificate of Death		ene g. No. 0 0 6	04456
-	Physic	ian	Decedent's Name (First, Middle, Last)		Date of Death     Month	_	3. Time of Death
	/Medi		Harry Cleveland Preston		January	30 2006	11:14 PM
4	Examir	ner	4a. Facility Name (If not institution, give street and number)  Cumberland Nursing Center	4b. City, Town, or Location of Death		4c. County of Death	
	Funeval		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	Cumberland  // If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Allegany	
	Funeral Director		214-16-2310 1\( \overline{\text{X}} \) M 2 □ F 82 Yrs.  Usual Residence of Decedent	Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 10	1923 Mary	place (State or Foreign oftry) Land
	yland		10a. State 10b. County 10c. City, Town or L	ocation.		1	0d. Inside City Limits
	a-fsl	ctor	MD. Allegany Rawlin	gs			1 ☐ Yes XXNo
	or 28	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	itry?
	ath w	rai	21427 McMullen Highway	21557		United Stat	
980	be filad within 72 hours after death with the Maryland ital Hygiene. Id other then "netural", or Items 23a or 28a-1 show of other then "netural", or Items 23a or 28a-1 show event, the Medical Examinar must be modified at	by Funeral	11. Marital Status  1 □ Never Married  1 □ Never Married  2 ◯ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Diver S □ □ No WW 2  If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto i 1 ☐ Yes 2 ★ O Specify:	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Wh	
5-0	72 h	etec	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of working	na 1	6b. Kind of Business/Inc	dustry
21215-0036	filad within Hygiene. Ither then "	Completed	unknown	e kind of work done during most of workin DO NOT use retired) Welder	]	Pipe Fittin	g
Maryland	2 should be fill and Mental Hy Is marked oth raumatic event	To Be	17. Father's Name (First, Middle, Last)  John Preston	18. Mother's Name	(First, Middle, M Laude)		
	2 = 7 I			ling Address (Street and Number or Rura 7 McMullen Highway,			
Baltimore,	00-		20a. Method of Disposition 20b. Place of Disposition cametery, cre	The state of the s	ate 2	oc. Location - City or To	wn, State
Balti	permit. Pag Department Important: I any injury o once.		17 7/6 //. /		al Funer		21562
			23a. Part1. Enter the disease, or complications that caused the death. Do not en				Approximate
	Physician /Medical		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  Due to (or as a consequence of):	ten disean			Interval Between Onset and Death
	Examiner		Sequentially list conditions				
	P #	iner	Sequentially list conditions, if any, feading to immediate cause. Enter Underlying Cause (Disease or injury				
	be executed sician and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of):				
8760,	ate be ex hysician the burial	calE	Due to (or as a consequence or):				
387	physicate sthe	edica	d				
O. Box 6	ne death certificate be executed the attending physician and thad for use as the burial-transii	Physician/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of delive Month	ry Day Year
Д	that the ded by the detachad		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to th	e cause of death?
ords,	v requires that the been signed by th should be detache	ted by	Knoboble Concinone of 4	ing	1 🗆 Yes	2□No 3DProb	abiy 4 ∐Unknown
of Vital Records,	Tha lav ate has page 2	Completed			24a. Was an autopsy perform	prior to cor death?	osy findings available inpletion of cause of 2 No
ita/	Physician: Th this certificate ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death		<del></del>	
Ž	shysic this ce al dire	2	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 ursing Hom	ne 5 🗆 Residen	ce 6 Other (Specify	)
ם	ding Ph h. After th funeral	on:	27. Manner of Death  1. ★Natural 5 Pending  28a. Date of Injury (Month, Day Year)  28b. Time of Month, Day Year)	of 28c. Injury at 2 Work?	8d. Describe how	injury occurred	
Sio	Attending r death. sctor: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be	M 1 Yes 2 No			
Division	= = = =	Certification:	4 Homicide determined 288. Place of injury - At nome, farm, st building, etc. (Specify)		City or Town,		
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	ledicai	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal physician: To the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurre	nd due to the cau d at the time, dat	se(s) and manner as st e and place, and due to	ated. the cause(s)
	To t To t	Σ	29b. Signature and title of certifie	29c. License number		. Date signed (Month, L	
,			- Myllin	90033280		Jan 31,200	) 6
			30. Name and address of person who completed cause of death (Item 23a) (Type Dr. Sunil Gupta, 625 Kent Ave., Cumk		21502		
	Sta Registr		31. Date filed (Month, Day, Year) 1 2006 32. Registrar's Signature	Land 1			

sicia edica		Stete     Registrar			Cer	tificate of	Death	R	jiene og. No. 0 0 1	6 0445
edica		1. Decedent's Name (First, Middle, La	ast)					2. Date of Dea Month	Day	Year 3. Time of Dea
	al -	Fred Jame 4a. Facility Name (If not institution, give		att		Ab City Town o	r Location of Dea	JAN	29 2 4c. County o	006 6
ımine	er			/		·	272011 17 22	lui		irrett
ral		279 Clifton Driv		ge (In yrs. las	st birthday)	If Under 1 Year		s. 8. Date of Birth		Birthplace (State or For Country)
tor			1 <b>万</b> M 2□F	92	Yrs.	Months Days	Hours Mir	Oct. 7,		West Virgi
	-	Usual Residence of Decedent		140.00						1404 1-14-09-1
		10a. State 10b. County		10c. City,	Town or Lo		l <b>an</b> d			10d. Inside City Li 1 ☐ Yes 2 2
	Director		rett			-	Tand			
		10e. Street and Number				10f. Zip Code			log. Citizen of W	
	era	279 Clifton Driv	12. Was Decedent	Ever in U.S.	13.1		1550 Ispanic Origin? (	Specify Yes or No-	US 14. Race	American Indian,
	Funerai	1 Never Married 2 Married	Armed Forces' 1 ☐ Yes 2 🔯	?	i			Specify Yes or No- rto Rican, etc.)	Black	k, White, etc.
١.	٦	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:			I□Yes 2⊠No	Specify:		Specify:	White
	Completed	15. Decedent's E			16a. Deced	lent's Usual Occup	ation	orkina	16b. Kind of Bus	siness/Industry
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,	ဦ	8th				Coal M				Mining
- 1	ă	17. Father's Name (First, Middle, Last	•				Josephi	me (First, Middle,	Maiden Sumame	P <b>asc</b> uzz <b>i</b>
1	ဍ	Michael	- Prat	L	405 14-111		•		Charten C	
		19a. Informant's Name/Relationship				-		Ru <i>ral Route Numbel</i> D <b>akland,</b> I	-	
1	-	Frederick M. Pra	tt/son	20b. Plac		sition (Name of	DIIVE,	Date		City or Town, State
	1	1 ⊠Burial 2 ☐ Cremation 3		cem	netery, cren	natory or other plac	1 - 1		Thomas,	
	-	<ul> <li>4 ☐ Donation 5 ☐ Other (Special Signature of Furreral Service Life</li> </ul>		Mt.		ry Cemete . Name and Addre		2/06	2 S. Sec	
ODCe.	-1	21. Signature of Fulleral Service Lite	1			tewart F	12 57			Md. 21550
	-	23a. Part 1. Enter the disease, or con	nnlications that cause	d the death.						Approximate
		23a. Part1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final			_					Interval Betwee Onset and Deat
n al		disease or condition resulting in death)		ATE (		<u> </u>				- 2 yrs
	Exam	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	s a conseque	nce of):	TATIC C				
	O	(	d		1100 01).					
	Medicai	IE EEMALE:	d		nce ory.					
	<b>O</b>	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d	2 Fetal de	cy eath 3	Ectopic pregnancy	,		23d. Date Mon	e of delivery th Day Year
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			T = For State Registrar	State of Ma	ryland <sup>6</sup>		irtment tificate			ınd M		giene Reg. Ne.	11116	0 1, 1	58
	Physic		Decedent's Name (First, Middle, Last)     SARA F. PERLIS								2. Date of De. JANUARY		2006		of Death
	/Medi Examir		4a. Facility Name (If not institution, give st MANOR CARE NURSING	,			4b. City, 1	Fown, or	Location of				County of De		
	Funeral Director		013-30-7272	7. Age	(In yrs. last bi	irthday) Yrs.	If Under	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birt (Month, Da FEB 3,	h 1911	9. B	irthplace (State Country)	or Foreign MA
	anyland show	ž	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tov	vn or Lo								10d. Inside	City Limits
	ith the M or 28a-f	Director	MD MONTGOME:	RY			POTOM 10f. Zip	Code				10g. Citiz	zen of What C	Country?	
36	be filed within 72 hours after death with the Maryland hat Hygiene. ad other than "natural", or itams 23a or 28a-f show event, the Madical Exerting Italias be retilified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ev Armed Forces? 1			Vas Decede Yes, speci	ent of His	20854 spanic Orig spanic Orig spanic Orig spanic Orig	jin? (Spe Puerto f	cify Yes or No- Rican, etc.)		U.S.A.  14. Race - Arr  Black, Wh  Specify: WF	nerican Indian, ite, etc.	
Baltimore, Maryland 21215-0036	e filed within 72 hor al Hygiene. I other than "naturi vent, IL MAGICAL	Completed	15. Decedent's Educe (Specify only highest grade Elementary/Secondary (0-12)			(Give	lent's Usual kind of work PO NOT use LAWY	k done di e retired)	urina most	of workir			nd of Busines	,	
land	should be filed and Mental Hygid markad other umatic event, II	To Be C	17. Father's Name (First, Middle, Last) MAX FINKELSTEIN					1			(First, Middle, ECCA MA		Sumame)		
, Mar,	and 2 sho alth and N 127 is ma er trauma		19a. Informant's Name/Relationship (Type BARRY R. PERLIS -								OMAC, M	. ,		Zip Code) 20854	
imore	permit. Pages 1 and 2 should be Department of Health and Menta Important: if itam 27 is marked any injury ocother traumatic ev		20a. Method of Disposition  1 Surial 2 ☐ Cremation 3 ☑ Re  4 ☐ Donatton 5 ☐ Other (Specify)	noval from State	20b. Place of cemete SHARO	ery, crem	atory or oth	her place	1		/2006		cation - City o		
l Balt	Departi Departi Import any inj		21. Signar fe of Burgral Service Licen	7		ED 10	Name and WARD 191 RC	SAGI CKVI	of Facility LLE I	NERAI PIKE	L DIREC , ROCKV	TION ILLE	, INC.	LAND :	20852
8760,	Physician and physician and physician and physician and physician ithe pniral-transit	dical Examiner	23d. Part1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	CORONARY  Due to (or as a  GENERAL  Due to (or as a  HYPERLIP  Due to (or as a	ARTER' consequence IZED A' consequence IDEMIA	Y DI of): THER of):	SEASE			ardiac oi	respiratory ar	rest,		Approxim Interval Bi Onset and	etween
P.O. Box 68	The law requires that the death certificat ate has been signed by the attending phy bage 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 25 No 9 □ Unknown	: If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at tir 9 □ Unknown	Fetal death		Ectopic pre Other (spe					2	3d. Date of de Month	elivery Day	Year
ds, P	uires that signed b Id be deta	d by Pt	Part II. Other significant conditions contr ATRIAL FIBRILLATION		not resulting i	in the un	derlying ca	use giver	n in Part I.					to the cause of	
Division of Vital Records,		Completed	OSTEOPOROSIS WITH N	MULTIPLE '	VERTEBI	RAL	COMPR	ESSI	ON		24a. Was a autop: perfor	sy	death?	utopsy finding completion of s 2 \( \text{No} \)	s available cause of
r Vita	ding Physician: The h. h. After this certificate ha tuneral director, page	To Be	25. Was case referred to medical examiner? X 1 Yes 2 1 No	spital: 1 🗆 Inpatient	2 ☐ <b>E</b> R/Oι	utpatient	3□ DOA	Other		•	(Check only or le 5 ☐ Resid		□Other (Spe	ecity)	
ion o		ertification: 7	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day )		Time of Injury		c. Injury Work 1 🗆 Y		2	8d. Describe h				
Divis	P F F	Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, fa (Specify)	arm, stre	et, factory,	office		2	8f. Location (S City or Tow	treet and n, State)	Number or R	lural Route Nu	mber,
	To the Hospital or within 24 hours after To the Funeral Direction completely filled in I	Medical (	29a. Certifier (Check only one) 1 Certifying Physic 2 Medicel Exemine	ian: To the best of r: On the basis of eand manner state	xamination ar	e, death	occurred at estigation, i	t the time	, date and nion, death	place, ai occurre	nd due to the c d at the time, d	ause(s) a late and p	and manner a place, and du	s stated. e to the cause	(s)
)	Vithi Com	Σ	29b. Signature and title of certifier	~	$\simeq$		29c.	License D3	number 55579				ARY 26	th, Day, Year) , 2006	
_			30. Name and address of person who com DR. SUSAN J. MILLER	R, 6844 T	ULIP H	ILL	TERRA	CE,	ВЕТНЕ	ESDA	, MARYL	AND	20816		
	Sta Registr		31. Date filed (Month, Day, Year) FEB 0 1 200	32. Registrar's	s Signature	Spa	soli)								

			1 - For State Registrar	State of Ma	arylan		artmen tificat				, ,	jiene	006	04459
1. 1	Division:	<b>F</b>	1. Decedent's Name (First, Middle, Last								2. Date of Dea Month		Year	3. Time of Death
	Physici /Medic		JEAN VINCEN	IZINA	PAGA	NO					JANUAR!	7 30	2006	8:15 A M
1	Examin	er	4a. Facility Name (If not institution, give			D.7	4b. City,	Town, or					County of Death	
			Casey House-6001 No. Social Security Number 6. Se			Rd.	If Under		vill If Under		8. Date of Birth		Iontgome	
1	Funeral Director			M 2 X F 7. A96	91	Yrs.	Months		Hours	Min.	March 1	, Year)	Coul	place (State or Foreign htry) W York
L			Usual Residence of Decedent							1	naron .			
	ahow dat	_	10a. State 10b. County			y, Town or Lo		T7 - 1 1 1						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
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	with ti	급	10e. Street and Number 19104 Mills Cho	nice Road	#4		10f. Zip	Code	2088	16		-	en of What Cou nited St	*
	filed within 72 hours after death with the Maryland Hygone. Ither than "natural", or itema 23a or 28a-f ahow wit, it a Medical Examinar must be notified at	by Funeral Director	11. Marital Status	12. Was Decedent E			Was Dece	dent of His			cify Yes or No-		4. Race - Ameri	
0	ifter d	Fun	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ N				. /			cify Yes or No- Rican, etc.)		Black, White,	
<u> </u>	ral', o		3 ⊠ Widowed 4 □ Divorced	If Yes, Give Year or Dates:			1 🗌 Yes	21 No	Specify.	:		5	Specify: V	White
21215-0036	72 h	Completed	15. Decedent's Edu (Specify only highest grad	ication le completed)		16a. Deced (Give	ient's Usua kind of wo	al Occupa rk done d	ition uring mos	st of workin	ıg	16b. Kin	d of Business/In	dustry
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N D	filed within Hygiene. other then	ပိ	12 17. Father's Name (First, Middle, Last)	0					18. Moth	er's Name	(First, Middle,			2
Maryland	0 = 0 >	To Be	Pasquale Fr	r <b>u</b> đa					Ros	e F	agano			
ary	shou and M mar umat	-	19a. Informant's Name/Relationship (T)	rpe, Print)			-					-	Town, State, Zip	
	and 2 Balth in 27 i		Helen Pagano / Per	rsonal Rep						ourt,	Montgor	nery	Village	,Md. 20886
altimore,	- I 3 =		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	Removal from State	20b. P	lace of Dispo emetery, cren	sition (Nai natory or c	me of other place	9)			20c. Loc	ation - City or To	own, State
Ē	tment of tant: If It		4 ☐ Donation 5 ☐ Other (Specify)	)	Me	tropol					./06		exandria	ı, Va.
Ba	permit. Departr Imports any Inje		21. Signature of Funeral Service Licens	Ball		22	. Name ar Murie	Addres	s of Facili Bar	ber F	uneral	Home	2	
	40244		23a. Part1. Enter the disease, or comp	lications that caused	the death		P. O.				aytons		Md.	20882 Approximate
E	Oleveriateur		shock, or heart failure. List only of immediate Cause (Final	ne cause on each lin	10.				,,		,	,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	aDue to (or as a		rcinom	la							
4	Examiner		Conventially list anaditions	b	,	,-								
	p #	Iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or injury	Due to (or as a	a conseq	uence of):								
	ecute and I-trans	Examiner		c Due to (or as a	a consequ	uence of):								
760,	certificate be executed iding physician and ise as the burial-transit	cal E												
68/	ficate g phys			3.										
Rox	leath certific attending p i for use as	In/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of			Ectopic p	2000000				23	3d. Date of deliv	өгу
	ed for	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at			Other (sp					-	Month	Day Year
О	at the de d by the etached	Phy	9 ☐ Unknown  Part II. Other significant conditions co			ulain nin ah a			a ia Baat		222 Did to			he cause of death?
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Ř	The lav sete has page 2	Completed									autop: perfor	sy med?	death?	opsy findings available impletion of cause of
Vital	a u	Be C	25. Was case referred to medical						26. Place	e of Death	(Check only or	2 No	1 🗌 Yes	2 □ No
	lysici lis cer direc	To B	examiner? 1 ☐ Yes 2 ∑ No	Hospital: 1  Inpatier	nt 2 🗆	ER/Outpatien	t 3 DC	Othe					Other (Special	hospice
0	ding Ph h. After th funeral		27. Manner of Death 1 ⊠ Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury	2	28c. Injury Work	al ?	2	8d. Describe h	ow injury	occurred	
<u>s</u>	tendi Jeath. tor: A the fu	catl	2 Accident investigation 3 Suicide 6 Could not be	00 01 (11)			М		/es 2 [		0( ) (0			
Division of	tal or Attendii s after death. al Director: A ed in by the fu	Certification:	4 Homicide determined	28e. Place of Inju building, etc	ry - At no :. (Specif	ome, tarm, str	eet, factor	y, office		2	City or Tow		Number or Hur	al Route Number,
	Hospital or Attending Physician: 44 hours after death: Funeral Director: After this certificiety filled in by the funeral director.		29a. Certifier 1∕€ Certifying Phy	sician: To the best of	of my kno	wledge, death	occurred	at the tim	e, date a	nd place, a	nd due to the c	ause(s) a	and manner as s	stated.
	To the Hospital or within 24 hours after To the Funeral Director completely filled in b	Medical	(Check only 2 Medical Exami	iner: On the basis of and manner sta	examina ted.	tion and/or in	estigation	, in my op	inion, dea	ath occurre	d at the time, o	ate and p	place, and due t	o the cause(s)
	To the within 2 To the complet	Σ	29b. Signature and title of certifier		m .		290	. License			2		signed (Month,	
	2				111(	7		D3	5635			Janu	ary 30,	2006
			30. Name and address of berson who c					1 D-	- L	\1	11. 25	3	20055	
T.	Sta	te	Joseph Kaplan, M 31. Date filed (Month, Day, Year)						a, R	OCKV1	lle, Mo	٨.	20855	
£.	Registr		FEB 01 2	006	ر می	B A								

			For State Registrar	State of Ma	aryland		artment of		and Me		ene g. No.	5 (	04461	Û
3/A:	Physici	an	1. Decedent's Name (First, Middle, La	•						2. Date of Death Month	Day	Year	3. Time of Dea	ath
	/Medic	cal	Dolores May	Pearson			4b. City, Town,	and anotion a		Sancra	4c. County o		1824	
-	Examir	ier	4a Facility Name (If not institution, give		Conte	4 )	46. City, Town,	Salice	hees		Wico		<b>^</b>	
200	Funeral			Sex 7. Age	e (In yrs. las	t birthday)	If Under 1 Yea			8. Date of Birth		9. Birthp	ace (State or Fo	oreign
	Director		222-12-9095	1□ M 200 F	75	Yrs.	Months Day	s Hours	Min.	(Month, Day, )3-15-19		Coun De1a	ware	
	pur *		Usual Residence of Decedent  10a. State 10b. County		10c. City. 7	Fown or Lo	cation					1	0d. Inside City L	imits
	f eho	ō		4.								Ι.	1 2 Yes 2	
	r 28a-	Director	MD Somerse  10e. Street and Number	<u>C</u>	Ed	len	10f. Zip Code		-	10	g. Citizen of Wi	nat Cour	itry?	
	h with		13603 Backbone	Road			21	822			U	SA		
	ams arms	Funerai	11. Marital Status	12. Was Decedent if Armed Forces?	Ever in U.S.	13.	Was Decedent of f Yes, specify Cu	Hispanic Original	gin? (Spec	ify Yes or No- ican, etc.)	14. Race Black	· Americ		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X	No		1 ☐ Yes 2 No				Specify:			
9	tural sel Ex	ed b	15. Decedent's E	Year or Dates:	Į .	16a. Dece	dent's Usual Occi	upation		1	6b. Kind of Bus		nite dustry	
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212	giene giene er the	Com	12	none	(+)	(	Clerk				U.S. Po	sta]	Servic	e
pu	should be filed within 72 hours after death with the Maryland Marked other then "natural", or liams 23a or 28a-f ehow marked other then "natural", or liams 23a or 28a-f ehow imatic event, the Madical Examinar must be notified at	Be	17. Father's Name (First, Middle, Last								faiden Sumame	)		
Zia	should ind Men marke umatic	2	Joseph W. Ferna					1		Merkel		-		
Maryland 21215-0036	2 6 9 2		19a. Informant's Name/Relationship (		Ï	Ser Service Action	ng Address (Stree				A CONTRACTOR OF THE CONTRACTOR	tate, Zip	Code)	
	s 1 and 2 of Health Item 27		Patricia Timmons, 20a. Method of Disposition	Daughter	20b. Plac	e of Dispo	Backbot sition (Name of		d, Ed		21822 :0c. Location - C	ity or To	wn, State	
פֿר	a o		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				natory or other pl Samily C		2/01/	'2006 E	den, Ma	rv1s	ınd	
altimore,	permit. Pagi Department Important: I eny Injury o	v	21. Fignature of Funeral Service Kice		rear	-	Name and Add			2000 1	den, na	Гута	illu	
ď	Ded In Personal		per & Clu	man A MI	00295		inman Fu 673 Som			Prince	ee Anna	MT	21853	
			23a Part1. Enter the disease, or com- shock, or heart failure. List only	plications that caused	the death.	Do not ent	er the mode of dy	ing, such as	cardiac or	respiratory arre	st,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Approximate Interval Betwee	
3	Physician		Immediate Cause (Final disease or condition	, 5	E PS	15							Onset and Deat  DAY	
	/Medical Examiner		resulting in death)	Due to (or as	a consequer	nce of):								
, A		35	Sequentially list conditions,	b	a consequer	nce of):								
	ried I	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	500 10 (0. 20										
o î	be executed sicien and burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequer	nce of):		.,					<del></del>	
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3 2 2	ertifica ling pt e as t	Med	IF FEMALE:											
Box	eath certific attending p	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1☐Live birth 4☐Pregnant at	2 Fetal de	eath 3	Ectopic pregnan Other (specify)	су			23d. Date Mont		Day Year	r
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J.	res that the de signed by the a be detached (	by Ph	Part II. Other significant conditions	contributing to death bu	ut not resultin	ng in the u	nderlying cause g	iven in Part I.		23e. Did tob	acco use contrib	oute to th	e cause of death	h?
202	w requires been sig should by	ed b	EMPHY	PSEMA						1 🗋 Ye	s 2□No 3	Prob	ably 4 ⊟trikr	nown
Division of Vital Records,	law re as bee 2 sho	Completed	COMON	ANT AR	TER	P 1	SEASE	5		24a. Was an	24b. W	ere auto	psy findings avai	ilable
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/Ita	Attending Physicien: Thr death. ector: After this certificete by the funeral director, pag	Be (	25. Was case referred to medical examiner?							(Check only one				
0	Physi this c	. To	1 Yes 2 No  27. Manner of Death	Hospital: 1 Impatie		VOutpatien 3b. Time of	t 3 DOA	ther: 4 🗆 Nu			nce 6 Other		/)	
0	ding I h. After funer	tion	1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day	Year)	Injury	W	uryat ork? ∐Yes 2.∐.l		od. Describe no	w injury occurre	,		
/ISI	Atten r deat octor: by the	fica	3 ☐ Suicide 6 ☐ Could not b	28e. Place of Inju		ə, farm, str						or Rura	l Route Number,	
á	s afte s afte el Dire	Certification:	4  Homicide determined	building, etc	с. (Бреспу)					City or Town,	State)			
	To the Hospitel or Attendi within 24 hours after death. To the Funerel Director: A completely filled in by the to	edicai (	29a. Certifier 1 Certifying Pt	nysician: To the best on miner: On the basis of	of my knowle	edge, death	occurred at the	time, date an	d place, an	nd due to the ca	use(s) and man	ner as st	ated.	
	the hin 24 the F	Medi	one)	and manner sta	ited.									
	P ₹ 2 8		29b. Signature and title of certifier	an 0				nse number	C		/a 9/o		Day, redr)	
			30. Name and address of person who			3a) (Type		116	9 0	/	10 110	6		
							*	5- <	Aile	avay.	MD 2	18	04	
Ģ ske	Sta		31. Date filed (Month, Day, Year)	32. Register	ar's Signatur	0		- 11 )	د اسار	~	-	-	,	
	Registr	ar	FEB 0 1	2006	Sur.	K	Coastes							

**Physician** /Medical Examiner

eny In

For State Registrar

10a, State

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Director

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21. Signatura

Physician

/Medical

Examiner

**Funeral** 

Director

with the state of

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Itsme 23

Baltimore, Maryland 21215-0036

ak per veni

with the Maryland

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician:

the

ner			
i Exami	ourial-trans	cian and	
Medical Certification: To Be Completed by Physician/Medical Examiner	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	To the Funeral Director: After this certificate has been signed by the attending physician and	
hysicia	tached for I	by the atter	
ted by P	ep ed pino	ben signed	
Сотріе	page 2 sh	cate has be	
To Be	al director.	this certific	
fication	y the funer	ctor: After	death.
ai Certi	y filled in b	neral Dire	hours after
Medic	completel	To the Fu	within 24 hours after death.

State

Registrar

29b. Signature

and title

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FEB 0 1 2006

Suquer tially list conditions if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	b. AORTIC STE Due to (or as a consec  CHRONIC OB Due to (or as a consec  d.	NOSIS juence of): STRUCTIVE	PULMONARY DIS	EASE	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of pregn. 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	il death 3 □Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	sulting in the underlying	cause given in Part I.		o use contribute to the cause of death? 2 ☑ No 3 ☐ Probably 4 ☐ Unknown
				24a. Was an autopsy performed?	
25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)	
1 ☐ Yes 2X No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 1	DOA Other: 4 Nursing F	lome 5 Residence	6 NOther (Specify) HOSPICE
27. Manner of Death  1 Xelatural 5 Pending 2 Accident investigation		28b. Time of Injury M	28d. Describe how in	jury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Special	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ite)		
29a. Certifier Certifying Ph	ysician: To the best of my knoniner: On the basis of examina	owledge, death occurre	ed at the time, date and place on, in my opinion, death occ	e, and due to the cause urred at the time, date a	(s) and manner as stated. and place, and due to the cause(s)

29c. License number

D35635

29d. Date signed (Month, Day, Year)

01/30/2006

JOSEPH KAPLAN, 6001 MUNCASTER MILL RD, ROCKVILLE, MARYLAND

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Rebecca Redden 30 JANIAM /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula legional redical Salisbo If Under 1 Year | Months | Days If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 KF Months Hours 217-44-1723 Director 63 12-23-1942 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location rthen "natural", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits Director MD 1 ☐ Yes 2 No Somerset Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 30529 Black Duck Lane 21853 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced "natural", White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be tiled within ; h and Mental Hygiene.
7 Is marked other then "r Elementary/Secondary (0-12) College (1-4or 5+) none Title Clerk Car Dealership permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked ofth eny lulury or other traumatic event RDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Melvin W. Gaskill Loretta Tarr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David H. Redden/Husband 30529 Black Duck Lane, Princess Anne 12, 21853 et of Disposition (Name of Duck Location City of Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 02/01/2006 Salisbury, Maryland ignature of Funeral Service Crensee .22. Name and Address of Facility Hinman Funeral Home Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac of respiratory arrest, shock, or heart failure. List only one cause on each line. 21853 Approximate Interval Between Onset and Death mediate Cause (Final sease or condition sulting in death) **Physician** heart failure Due to (or as a consequence of): Years /Medical Examiner Hypertenson Sequentially list curvations, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine physicien and s the burial-transit The law requires that the death certificate be executed Chronic Kenal Due to (or as a consequence of): Box 68760. Physician/Medical for use ?? IF FEMALE 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death signed by the eld be detached for 5 Other (specify) o 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Hiknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? page 2 has autopsy performed certificate of Vital 1 Yes 1 ☐ Yes 2 ☐ No 2 4 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No P 1 Inpatient 2 ER/Outpatient 3 DOA this After the funeral c 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 5 Pending investigation Injury death. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu М 1 Tyes 2 No 2 Accident 6 Could not be determined 3 🗆 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number DO041211 1, ale, und Terrando 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. Corroll St. Salisbury, md 21801 errando Itcle 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 1 2008 Green & Specie Registrar

			1 - For State Registrar			nd / Depa		t of H	lealth a		lental Hy		06	04464
	Physici		Decedent's Name (First, Middle, I)  Judy Ann Selby	.ast)							2. Date of De. Month Februa		2006	3. Time of Death 12:55 PM
	/Medic Examin		4a. Facility Name (If not institution, g		ber)		4b. City, Frier		Location o	of Death		4c. Cou	unty of Death	
	Funeral Director		5. Social Security Number 6 182-54-6203	If Under Months	1 Year Days	If Under Hours	Min.	8. Date of Bin (Month, Da April	10 22,1958	9. Birthp Cour Penn	place (State or Foreign htry) sylvania			
e, Maryla	the Maryland 28a-f show rollfied at	rector	Usual Residence of Decedent  10a. State 10b. County  MD Garret  10e. Street and Number	t		ty, Town or Lo		Code				10g. Citizen	of What Cour	0d. Inside City Limits 1 □ Yes 2X No
	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene if Health and Mental Hyglene item 27 is marked other than "netural", or Items 23a or 28a-f show other treumatic event, the Medical Exertifier must be rollined at	y Funeral Director	1545 Mill Run Ro	12. Was Deced	ces? 2 ⊠ No 3	į į	Was Deced	dent of Hi cify Cuba	ispanic Ori n, Mexican Specify:	gin? (Spe n, Puerto	ecify Yes or No Rican, etc.)		Race - Americ Black, White,	etc.
	within 72 hours ene. than "netural" he Medical Ex	Completed by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest state)  Elementary/Secondary (0-12) 12	Year or Da Education prade completed)  College (1-		(Give	dent's Usua kind of wor DO NOT us tarv	rk done d	during mos	t of worki	ing	16b. Kind o	Whi	
	should be filed ind Mental Hygid marked other umatic event, II	To Be Co	17. Father's Name (First, Middle, La William E. Griff	ith				/04	Evel	yn R	e (First, Middle, uth Det	Maiden Sun rick	name)	Cody
	ges 1 and 2 sho tt of Health and If item 27 is m or other treum		19a. Informant's Name/Relationship  Jimmie L. Selby/  20a. Method of Disposition  1□ Burial 2 X Cremation 3	Husband		1545 Place of Dispo	Mill osition (Nam matory or o	Run ne of ther plac	Rd.,	Fri	endsvil Date . 6, 20	le, MD	2153 on - City or To	B1 own, State
Baltimore,	permit. Pages Department of h Importent: If ite any injury or of		4 □ Donation 5 □ Other (Spe     21. Signature of Furieral Service Lice		au	22	2. Name an	d Addres	ss of Facilit	y New	man Fur sville	neral		
760,	physician and physician and sthe burial-transit	ical Examiner	23a. Part1. Enter the disease, or or shock, or heart-failure. List or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate the first landship Cause (Disease or injury that initiated events resulting in death) Last	a. ue to (c	or as a consequence or a consequence or a consequence or a consequence or a consequenc	quence of):	1 C		an					Approximate Interval Between Onset and Death
.O. Box 68	es that the death certifica igned by the attending ph be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		nth 2 ☐ Feta unt at time of c	al death 3	⊒Ectopic pr ⊒ Other (sp					23d.	Date of delive Month	ory Day Year
<u>α</u>	The law requires that I ate has been signed by page 2 should be deta	þ	Part II. Other significant conditions	contributing to de	ath but not res	sulting in the u	inderlying c	ause give	en in Part I.		23e. Did to			ne cause of death?
Vital Records,		Completed	25. Was case referred to medical						GO Diversi		1 🗆 Yes	osy rmed? 2 No	prior to co death?	psy findings available mpletion of cause of
P O	ding Phys	atlon: To Be	examiner?  1 Yes 2 Ho  27. Manner of Death  1 Natural 5 Pending investigat	28a. Date o (Month		ER/Outpatier 28b. Time o Injury		8c. Injun Worl	er: 4 □ Nu	rsing Ho	n <i>(Check only d</i> me ➤ Pesic 28d. Describe h	dence 6 🗀	curred	
Division	Hospitel or Attend 24 hours after death Funeral Director: itely filled in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine	289. Place	of Injury - At h g, etc. (Specil	ome, farm, sti fy)	reet, factory	, office			28f. Location (3 City or Tox		umber or Rura	al Route Number,
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medical Ex	Physician: To the laminer: On the ba and mann	sis of examina		vestigation	, in my o <sub>l</sub>			ed at the time,	date and place		the cause(s)
	To with		29b. Signature and title of certifier	iln	0	200	0	H2	-61	Si	{	Z	3	06
			30. Name and address of person when P. Dawie	Willa	VD	0 6	Print)	olt	Ac	ves	Dv &	rak	land	CM +
	Sta <b>Reg</b> istr		31. Date filed (Month, Day, Year)	2006 32. Re	gistrar's Signa	ature	Court .	A						71838

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Judith Connor Sullivan January 29, 2006 3:45 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Silver Spring

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
Nov. 6, 1936 Holy Cross Hospital Montgomery 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 047-28-6517 69 Massachusetts Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show Examiner must be notified at 1 Yes 2 No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 8750 Georgia Avenue, #301B 20910 USA items 23a Funeral death 1 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural', or 1 ☐ Yes 2 ☒ No Specif.White Specify 2 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Artist Own Business permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if Ikem 27 is marked other then yinjury or other treumatic event, Imponee. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Roger W. Connor Dorothy Dunham 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas John Sullivan/ Husband 8750 Georgia Avenue, #301B, Silver Spring MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State February 2006 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Francis Adress Collins Funeral Home Inc Will 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Congestive Heart Failure Physician /Medical Due to (or as a consequence of) Examiner Cor Pulmonale Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Pulmonary Hypertension burial-transi that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760. attending physician Physician/Medical Status Post Repaired Ventricular-Septal Defect as the IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Dav Year 4☐Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Right Arm Cellulitis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? certificate 2 🔀 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one) Hospital: 1 fnpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐XNo 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 X Natural death 1 ☐ Yes 2 ☐ No Director: / 2 Accident 3 🗀 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funerel C Medicai 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Ambient Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) To the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 200 63343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Irina Ruban, M.D. 1500 Forest Glen Road, Silver Spring MD 20910 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 0 1 Registrar

			, roi	rtment of Health and Mental H tificate of Death	Reg. No. O C O L C C
	Physici /Medic	al	John Artze Sharon  4a. Facility Name (If not institution, give street and number)	Month Febru 4b. City, Town, or Location of Death	uary 2 2006 Olovan
	Examin Funeral Director	er	15408 Fairview Road  5. Social Security Number  6. Sex  1 XM 2 □ F  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)  7. Age (In yrs. last birthday)	Hagerstown	Birth Day, Year) 29 1931  Washington CO.  9. Birthplace (State or Foreign Country) Maryland
	Maryland 8-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation rstown	10d. Inside City Limits 1 □ Yes ※□ No
9800	72 hours after death with the Maryland natural', or Itams 23a or 28a-f show liest Exter in the mart be mutilised at	d by Funerai Director	1 □ Never Married 2 ☑ Married 1 ② Yes 2 □ No If Yes, Give 1 Year or Dates:	10f. Zip Code  21740  /as Decedent of Hispanic Origin? (Specify Yes or Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2 ☒ No Specify:	Specify: White
21215-0036	- 10	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Weld		16b. Kind of Business/Industry  Crane Mfg.
Maryland	2 should be filed withir and Mental Hygiene. is marked other than aumatic avant, Its Ma	To Be (	17. Father's Name (First, Middle, Last)  Charles Henry Sharon  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing	18. Mother's Name (First, Mid Clara Elizabe Address (Street and Number or Rural Route Num	eth Patton
	s 1 and 2 st if Health and itam 27 is n other traun		Elizabeth May Sharon 1540  20a. Method of Disposition 20b. Place of Dispos	8 Fairview Rd. Hagersto	
Baltimore,	permit. Pages 1 Department of H Important: If its any injury or otl		1 Signature of Funeral Service Licensee 22.	Cemetery 2-6-06  Name and Address of Facility Douglas	Williamsport Maryland s A. Fiery Funeral Home gerstown Maryland 21742
1760,	Physician and was partial in the principle of the princip	Ical Examiner	23a. Part1. Enter the disease, or comolications that caused the death. Do not enter shock, or heart taltire. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	r the mode of dying, such as cardiac or respirator	Interval Between
.O. Box 687	death certifica e attending ph d for use as ti	Physician/Medic		Ectopic pregnancy Other (specify)	23d. Date of delivery Month Day Year
ecords, P.	requires that the deen signed by the tould be detached	by	Part II. Other significent conditions contributing to death but not resulting in the un Interstial pulmonary Fiscosis, Chi	derlying cause given in Part L. 23e. D	id tobacco use contribute to the cause of death?  Yes 2 \( \sum \text{No} \) 3 \( \sup \text{Probably} \) 4 \( \sup \text{Unknown} \)
$\mathbf{\alpha}$	The law ate has by page 2 sh	e Completed	Aviel Fibilition	pe 1 ☐ Ye	utopsy prior to completion of cause of death? s 2 No 1 Yes 2 No
ion of Vital	ding Phys h. After this funeral dii	To B	25. Was case referred to medical examiner?  1		esidence 6 Other (Specify) be how injury occurred
Division		Il Certification;	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, stre building, etc. (Specify)  29a. Certifier  29a. Certifier  29a. Certifier	City or	n (Street and Number or Rural Route Number, Town, State)
	To the Hospital or within 24 hours after To the Funeral Dircompletely filled in	Medical	29a. Certifier  (Check only one)  2   Medicel Exeminer: On the basis of examination and/or invitable and manner stated.		
			30 Many and address of person who completed cause of death (Item 23a) (Type. F	026406;	My ND 21742
SHO	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	ravio Hue Hogos	man MJ 21742

DHMH 17 Rev 1/2001

ORIGINAL

		-	For State Registrar	State of Ma	aryland		artment of F		and Me		jiene	006	04467	
			Decedent's Name (First, Middle, L.)	ast)			1		2	2. Date of Dea Month		Year	3. Time of Death	-
	Physicia		Esther	A.	Sic	hus	ter		J	anuary		2006	12:35 P <sup>M</sup>	
	/Medic Examin		4a. Fecility Name (If not institution, g	ive street and number)			4b. City, Town, o	r Location o	of Death		4c. (	County of Death		
			Anchorage Nursing	and Rehab	)		Salisbur		rylan	d		comico		_
	Funeral Director		144-18-4419	Sex 7. Ag 1 M 2 1 F	e (In yrs. las	Yrs.	If Under 1 Year Months Days	If Under a	Min. S	Month, Day Septemb	er29	,1921 N	plece (State or Foreign ntry) ew Jersey	_
	pur *	1	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Lo	ocation						10d. Inside City Limits	
	72 hours after death with the Maryland "natural", or Itema 23e or 28e-f ehow salical Exercities must be multied at	5	Maryland Wicomic	70	Salis	sbury							1 ☑ Yes 2 ☐ No	
	the 28a-	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of What Cou	intry?	
	3e or		105 Times Square				21801				USA			_
	death ma 2	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	. 13.	Was Decedent of H	lispanic Ori	gin? (Spec	ify Yes or No- ican, etc.)	1	14. Race - Ameri Black, White		
ဖွ	after or ite		1 Never Married 2 Marned				1 ☐ Yes 2 🛣 No	Specify:		,		Specify:		
93	ural',	d by	3 Midowed 4 ☐ Divorced	Year or Dates:								Whi nd of Business/Ir		_
21215-0036	be filed within 72 ho ntal Hygiene. of other then "nature event, the Massical	Completed	15. Decedent's (Specify only highest of	Education grade completed)		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retire	oation <i>during</i> mos d)	t of working	,	160. Kir	nd or Business/ir	ndustry	
121	within ene. then "	dm	Elementary/Secondary (0-12)	College (1-4or			ician	<i>o</i> ,			Boatt	ity Shop		
	filed within Hygiene. other then		12. Father's Name (First, Middle, La	st)		peaul	ICIAII	18. Mothe	er's Name (	First, Middle,				
an	d be ental ked o	To Be	Alvin Bean					Berth	na Mab	el Whi	te B	Bean		
Maryland	2 should be f and Mental H ie marked of aumatic eve	1	19a. Informant's Name/Relationship	(Type, Print)			ng Address (Street							
	permit. Pages 1 and 2 should Department of Health and Men Important: If item 27 ie marke any injury or other traumatic once.		Gail Stephens/Day	ughter	1	202 S	heffield	Ave.	Salis	bury,	Mary	rland 21	804	
re,	s 1 and 3 of Health item 27 other tr		20a. Method of Disposition		20b. Pla	ce of Disponetery, cre	osition (Name of matory or other pla	сө)	Da	te	20c. Lo	cation - City or T	own, State	
Baltimore,	permit. Pages. Department of timportant: If ite any injury or of		1 ☐ Burial 2 ☐ Cremation 3  '4 ☑ Donation 5 ☐ Other (Spe		Anat	omy ( istry	Gifts		01/30/	<b>/</b> 06	Hanc	ver, Var	vland	
alti	permit. Departminite importa		21. Signature of Funeral Service Lie	nee	11.29	2	2. Name and Addre	ss of Facilit	ty				# married Const.	
m	88 1 28	1. 2	Keell &	kreney (	KID		01 Snow I	Hill F	Rd. Sa	alisbur	y, M	Maryland		-
· Q			23a. Part1. Enter the disease, or co shock, or heart lailure. List on	mplications that cause ly one cause on each i	d the death. ine.								Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition	AS1	PIR	ATI	ON	PN	EUI	MON	IA		IWETK	
NE.	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):	h						14EAR	
*	LAdimine	_	Sequentially list conditions,	b. <u>Dyg to (or as</u>	5777	(7/1	T						116.116	_
	pe is	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to (or as	ME	- N	TIA						ZYEARS	
	xecut and al-trar	Examiner	that initiated events resulting in death) Last	c. Due to (or as	a conseque	ence of):								
760,	te be executed ysician and te burial-transit	calE		4										
687	5 × 6			d.	-						1			_
Box	nding use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome			Terrorio erognos				2	23d. Date of deli	•	
-	death atte	iciai	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐Live birth 4 ☐ Pregnant a			⊒Ectopic pregnand ⊒ Other (specify) _	у				Month	Day Year	
P.O.	t the by the ache	hys	9 Unknown	9□ Unknown							-			
	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the burial	by P	Part II. Other significant condition				underlying cause gr	ven in Part I	l.				the cause of death?	
Records,	anna J plno	ted	TITITU	~ =	CUR			1 0	-	10,	165 21			
ecc	law re as be 2 sh	Completed	SACRE	IL De	-u B	114	7 0	LC		24a. Was autop	osy	24b. Were au prior to death?	topsy findings available completion of cause of	
H		Son								1 Yes	rmed2 2 No		2 🗆 No	
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?					han /		(Check only o				
of	hysi this c	은	1 Yes 2 No		ient 2 🗆 E	R/Outpatie	nt 3 DOA	4 N		ne 5 🗌 Resid 8d. Describe I		6 □Other (Spec	cify)	-
'n	fe life	lon	27. Manner of Death  1 ☐Natural 5 ☐ Pending	28a. Date of Inj (Month, D	ay Year)	Injury	Wo	ork? ]Yes 2.⊡		04. 50001150 1	1011 111/01	, 33344		
isio	Attanding r death.	cat	2 Accident investiga 3 Suicide 6 Could no	t be 28e. Place of Ir	niury - At hor	me, larm, s	treet, lactory, office						ıral Route Number,	
Division of	after Direction by	Certification:	4 ☐ Homicide determin	ed building, e	itc. (Specify)	)	,,			City or To	wn, State	)		
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certific completely filled in by the funeral director.	aic	29a. Certifier 1 Certifying	Physician: To the bes	t of my know	vledge, dea	th occurred at the t	me, date a	nd place, a	nd due to the	cause(s)	and manner as	stated.	
	P Ho 1 24 h 19 Fur	Medical	(Check only 2 Medical E.	kaminer: On the basis and manners	of examinati tated.	on and/or i	nvestigation, in my	opinion, de	ath occurre	d at the time,	date and	d place, and due	to the cause(s)	
	withir To th	×	29b. Signature and title of certifier	M		1	29c. Licer	se number	10	260	29d. Dat	te signed (Monti	h, Day, Year)	1
	20			/acc	4	1	D	4	61	02	VAI	VUHIC	-7 51, 2001	b
	MB		30. Name and address of person w	ho completed cause of	death (Item	23a) (Type	Print) W / P	VTE	n/	PLAC	E.	MI	24 31, 2001 24 31, 2001 21804	
8	St Regist	ate rar	31. Date liled (Month, Day, Year)	32. Regis	trar's Signat	ure	A de							

DHMH 17 Rev 1/2001

ORIGINAL

			1 - For State Registrar	State of Mary		artment of F rtificate of			iene g. No. 006	04469
	- A		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death		3. Time of Death
ı	Physici /Medi		William Neal TR	ENT Sr.				January	30 2006	0944 PM
6.	Examir	ier	4a. Facility Name (If not institution, give	e street and number)		4b. City, Town, o	r Location of Death	1	4c. County of Death	
Ø		<i>-</i> ;	Washington Count			Hagers			Washingt	
F	Funeral Director		5. Social Security Number 6. S	<b>1</b> M 2 □ F	yrs. last birthday) Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) Coui	**
			217-36-5697 Usual Residence of Decedent	63				Sept. 1	2 1942 Mar	yland
	yland		10a. State 10b. County	10	c. City, Town or Lo	ocation			1	0d. Inside City Limits
	e Ma	cto	Maryland Washing	ton	Нае	erstown				1 ☐ Yes 2√2 No
	or 28	Director	10e. Street and Number		- 0	10f. Zip Code		10	g. Citizen of What Cour	ntry?
	ath w	Ta .	12324 Delwood Aver			2174			USA	
	er de item	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?		Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sr an, Mexican, Puert	pecify Yes or No- p Rican, etc.)	14. Race - Americ Black, White,	
36	irs aft	by F	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 ☑ Yes 2 ☐ No If Yes, Givel 964 Year or Dates:	-70	1 ☐ Yes 2 🎇 No	Specify:		Specify: Wh	nite
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or items 23e or 28e-f show he Medical Examinar must be notitied at	led	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation		6b. Kind of Business/in	dustry
215	hin 7.	pie	(Specify only highest gra	completed) College (1-4or 5+)	(Give	kind of work done DO NOT use retired	during most of won d)	king		,
	filed wil Hygien other tha	Completed	12	0	Truck	Driver		Fu	el Distrib	ution
Maryland	2 should be filled withir and Mentel Hygiene. Is marked other than aumatic event, the Ms	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle, M	fa <i>iden Suma</i> me)	
<u> </u>	should ind Men ind marke umatic	မ	Floyd Trent					e Hungate		
Nar Nar	ges 1 and 2 should be filed within 72 hours after death with the Marylar It of Health and Mentel Hygiene. If Item 27 is marked other than "natural; or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (7		19b. Maili	ng Address (Street	and Number or Ru	ral Route Number,	City or Town, State, Zip	Code)
	of Health item 27 other tr		Leona Hall - Daugh 20a. Method of Disposition	nter	1213	Pinecres	t Avenue	, Hagerst	own, Md. 2	1740
סַר	Pages nent of l int: if its		1   Burial 2 ☐ Cremation 3 ☐	Inditional Holli State	cemetery, crei	sition (Name of matory or other place	ce)	2	Oc. Location - City or To	wn, State
altimore,			4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen			n Mem. Pa			Magerstown,	Maryland
Ba	permit. Depertin Imports any inju		21. Signature of 7 undatal Service Electric	mm		Name and Addre	11.		neral Home	17/0
1			23a. Part 1. Enter the disease, or comp	olications that caused the					stown, Md.	ZI/40 Approximate
	Physician		Immediate Cause (Final	one cause on each line.	dio vo	shila	tory	Fail	1,80	Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as a co	nsequence of):	7			1	en Hours
	Examiner			Con	mak	y ACT	ery D	'Sease	6	Car Year .
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	nsequence of):					1000
	cutec	Examiner	that initiated events	c. Dia	bete	8 M	ellit	us II	Se	veral /vs
Ö,	ate be executed thysician and the burial-transit		resulting in death) Last	Due to (or as a co	1 -	- 6				414
8760	ate the	dicai	•	a. Hype	rcip	(den)	9			well /13
9	eath certific attending p	Med	IF FEMALE:	00- 14						
Вох	attend for us	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pr	Fetal death 3[	Ectopic pregnancy			23d. Date of delive Month	ny Day Year
o	that the de ed by the a detached t	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time 9□Unknown	or death 5L	Other (specify)				
a.	The law requires that the death certific lie has been signed by the atlending p page 2 should be detached for use as	/Ph	Part II. Other significant conditions co	gatributing to death but no	t resulting ip-the u	nderlying cause giv-	en in Part I.	23e. Did toba	acco use contribute to the	e cause of death?
Records,	uires I sign Id be	d by	Chronic 8	estructo		mohan	y disease	1 ☐ Yes	s 2 □No 3 Prob	ably 4 □Unknown
Ö	w require	Completed						24a. Was an	24h Word auto	osy findings available
Re	The lav	mc						autopsy	ed? prior to cor	notetion of cause of
Vital		0	25. Was case referred to medical				26 Place of Door	1 ☐ Yes 2	X No 1 ☐ Yes	28 No
	Physician: r this certifica ral director, p	To B	examiner?	Hospital:	2 KER/Outpatier	t 3 DOA Oth			nce 6 Other (Specify	41
Division of	Attending Physician: or death. sctor: Atter this certific by the funeral director,		27. Manner of Death	28a. Date of Injury (Month, Day Yea				28d. Describe how		'/
Ö	ath. or: Af	atio	1 Natural 5 Pending 2 Accident investigation		o/ injury		Yes 2 □ No			
<u>%</u>	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S)	At home, farm, str	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	itai o irs af rei D									
	Hospital or Attendir     A hours after death.     Funeral Director: At etely filled in by the fut	edicai	Z Medical Exam	ysician: To the best of my	knowledge, death mination and/or in	occurred at the time vestigation, in my or	ne, date and place, pinion, death occur	and due to the cau	use(s) and manner as st	ated.
	To the Hospital within 24 hours a To the Funeral completely filled	Med	29b. Signature and title of certifier	and manner stated.						
	Ž Š Ž	_	A A A	and i)		> RICHASE	5447	29	u. Date signed (Month, 1	o L
7			VIIINULI		(h	1	-//(			
51	4611		30. Name and address of person who	ASIA	(item 23a) (Type,	122 D1	PAL CO	- HACO	ERSTOWN	NO
30	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	1 . N's A		, , ,,,,,,	d. Date signed (Month, )  2 - 2 -  EPS TOWN	21740
100	Registr	ar	EER 0.3.2	11 17 Page	N: 67	he reflected				,

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Bay 30 **Physician** Month 1.08 PM Donna Jean Vogt Januar DOOL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 1 F Director 212-76-7081 43 December 6 1962 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Directo 1 Yes 2 No Washington Maryland Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 531 Surrey Ave 21740 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Completed by 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene important: if Item 27 is marked other than "nany injury or other trainment. Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Domestic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wendell Carlton Swenson Joan Elkjer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Wayne Swenson / Brother 7922 Delmont Station RD Severn Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2/1/2006 Smithsburg Maryland 21. Signalus Funeral Service Licens 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave Hagerstown MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Hepatorena /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine the attending physicien and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Box 68760. The law requires that the death certificate be oten Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Day Month Year 4☐ Pregnant at time of death P.O. I 5 Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 00 1 3 Probably 1 ☐ Yes 2 □ No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Wasan autopsy performed? 0 certificate Vital 1 ☐ Yes Hospital or Attending Physician: After this certification funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 2 1 Unpatient 2 ER/Outpatient 3 DO 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) of 27. Manger of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28d. Describe how injury occurred Division 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours after within 24 hours a' 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2000 6/11 Jan My un 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUTTE 10/5 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item#5,perFH,0353,3/10/06 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day ; **Physician** Year Mary Lucille Wells 7:50 AM 25 2006 /Medical MUA 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's Social Security Number 577–32–2653 579–12–4466 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Date of Birth (Month, Day, 6/7/25 **Funeral**  Birthplace (State or Foreign Country) Days Months Year 1 ☐ M 2 💆 F Director 80 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location or 28a-f show 10d. Inside City Limits the Medical Exercitivar must be notified at P.G. Director 1 XYes 2 ☐ No Md. Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5000 Collington Road 238 20715 U.S.A. a filed within 72 hours after death wit Hygiene.
other than "natural", or Iteme 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 African-1□ Yes Ž No Specify: Specify: þ 3 Widowed 4 □ Divorced American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Nurse Hospital permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any njury or other traumatic event 2005. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Vincent D. Thomas Mary L. Brown 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clara M. Thomas/Sister 4602 Collington Rd., Bowie, Md. 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑Burial 2 ☐Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 2/4/06 Landover, Maryland 21. Signature of Funeral Service Licensee Name and Address of Facility
H.S. Washington & Sons Co., Inc.
4925 Burroughs Ave., N.E., Wash., D.C. auro 23a. Part1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Collapse Circulatory Min ste /Medical Due to (or as a consequence of): Examiner Contraintentual Hensinka Work assive if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physicien and tor use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Be Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery signed by the atte 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 26 tuneral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Sunpatient Certification; To 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Atter 1 Natural 2 Accident Injury 5 Pending 24 hours after death. • Funeral Director: A 1 Yes 2 No investigation the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospitai Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune completely fi (Check only one) 29b. Signature and tytle of certifie 29c. License number 29d. Date signed (Month, Day, Year) 00052865 January cal se of death (Item 23a) (Type, Print) 30. Name and address of person who complete K. Michael Figaro, M.D. 3001 Hospital Drive, Cheverly, Maryland 20785 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 3 1 2006 Registrar

		1 - For State Registrar		aryland / De	epartment of Certificate of	Health and	Mental Hygi	-	04472
Physici	20	Decedent's Name (First, Middle, La	st)				Date of Death     Month	Day Year	3. Time of Death
/Medic		Louise	Р.	Wh	itehead		January 30		11:45 A M
Examin	er:	4a. Facility Name (If not institution, giv				, or Location of Deat	h	4c. County of Dea	
\$ 1 m	N.	Southern Maryland			Clintor			Prince Geo	
Funeral		5. Social Security Number 6. S 051-24-3649	I M ARTE	e (In yrs. last birtho Yr	Months Day		(Month, Day, 1		thplace (State or Foreign ountry)
Director		Usual Residence of Decedent	80	)	3.		March 16,	1925	Maryland
land ow		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Man	ţō	Maryland Prince G	eorge's	Temple H	ills				1 Yes 2 No
r 28e	rec	10e. Street and Number			10f. Zip Code	)	100	g. Citizen of What C	ountry?
h wit	a D	5911 Lambert Drive			207	748		USA	
be filed within 72 hours after death with the Maryland be filed within 72 hours after death with the Maryland be filed with green of other than "natural", or items 23a or 28e-f ahow event, the Madical Examirar must be notified at	Funeral Director	11. Marital Status	12. Was Decedent 8 Armed Forces?	Ever in U.S.	13. Was Decedent of If Yes, specify Cu	f Hispanic Origin? (S	pecify Yes or No-	14. Race - Am	erican Indian,
or ftu	F.	1 ☐ Never Married 2 Married	1 ☐ Yes 2¥24 N	10	1 ☐ Yes 2XXN		to rican, etc.)	Black, Whi	
ural',	d by	3 Widowed 4 Divorced	Year or Dates:		I as Savia	о зрвсну.		Specify:	White
d within 72 hours af giene. or than "natural", or the Medical Exam.	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(0	ecedent's Usual Occ Give kind of work don	ne durina most of wor	rking 16	6b. Kind of Business	/Industry
ha e di	ш	Elementary/Secondary (0-12)	College (1-4or 5	+)	fe. DO NOT use reti	red)			
iled v Hygie ther t	ပိ	17. Father's Name (First, Middle, Last	1	Hot	memaker	da Markada Na	ne (First, Middle, Ma	In Home	
d 2 should be file th and Mental Hy ?? Is marked oth traumatic event	To Be	Additson Painter	,				t Lori Hunte	,	
should be ind Menta marked umatic ev	P	19a. Informant's Name/Relationship (	Time Driet	1 40 4					
d 2 s th an 7 le r traur			30		failing Address (Stre				Zip Code)
C = 44 =		Clarence L. Whitehead 20a. Method of Disposition	/ Husband	591.	Lambert Dr isposition (Name of	ive Temple I	Hills, Maryl	oc. Location - City or	
Dermit. Pages 1 a Department of Hez mportent: If Item any Injury or othe		1 ☐ Burial 2 ☒ Cremation 3 ☐		cemetery,	crematory or other p	lace)			
permit. Page Department of Importent: If any Injury or		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Line)	207 100	Kalas C	-		l/2006 E	dgewater, M	aryland
Depa Impo		21. Signatur of Fulleral Service Cos	Lite		22. Name and Add	George	rge P. Kalas	Funeral Ho	ne PA
		23a. Part1. Enter the disease, or one shock, or heart failure. List only	nlications that caused	the death. Do not	OTO OVOIL	TILLI VOGO (	JXOH HILL, M	arviand /	0745 Approximate
Physician Medical Examiner Library Lib	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a b. Due to (or as a c.	a consequence of) a consequence of)		mi4			Onset and Death
the deeth certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome  1 Live birth  4 Pregnant at  9 Unknown	2 Fetal death	3 Ectopic pregnar 5 Other (specify)			23d. Date of de Month	livery Day Year
law requires that es been signed b	þ	Part II. Other significant conditions of	contributing to death bu	ut not resulting in th	ne underlying cause (	given in Part I.			o the cause of death?
w require been sig	Completed								
he la e hes age 2	E I						24a. Was an autopsy performe	prior to	utopsy findings available completion of cause of
	CO	25 Man once referred to madical		····			1 ☐ Yes 2 [	No 1 ☐ Yes	2 2 No
Physicien: The law rthis certificate has b ral director, page 2 s	8	25. Was case referred to medical examiner?	Hospital:			Atha a se	th (Check only one)		
Phy rthis	2	1 Yes 2 No	1 Lumpatiei		Ment 30 DOX	4 🗆 Nursing n	ome 5 Residen		icify)
ding Phy h. After thi funeral	to	1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) Inju	ry W	ork? □Yes 2□No	280. Describe from	mjury occurred	
el or Attending s after death. al Director: Afte ed in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	θ 20a Diago of Inju	iry - At home, farm (Specify)	, street, factory, office		28f. Location (Stre City or Town,	et and Number or R State)	ural Route Number,
To the Hospitel within 24 hours and the Funerel I completely filled	Medical (	29a. Certifier   1 Certifying Ph (Check only one)   2 Medical Exam	nysician: To the best on the basis of and manner sta	examination and/o	eath occurred at the r investigation, in my	time, date and place opinion, death occu	, and due to the cau rred at the time, date	se(s) and manner as e and place, and due	s stated. e to the cause(s)
within comp	Σ	29b. Signature and title of certifier			29c. Lice	nse number	290	d. Date signed (Mont	h, Day, Year)
(0)		Norm-	my		Do	055140		Tanjam 3	0 2006
0 (8)		30. Name and address of person who Richard Paline	completed cause of de	eath (Item 23a) (Ty		Shite 310	Washingh	in DC 20	037
Sta Registr		31. Date filed (Month, Day, Year)  JAN 3 1 2006	32. Registra	r's Signature					

				State of		epartment of Certificate	of Health and M of Death		giene: () (	16	04473
	Physici	an	Decedent's Name (First, Middent's Name (	- 1	. 1	1		2. Date of Dee Month	Dey	Yeer	3. Time of Death
1	/Medi	al	4a. Fecility Name (If not institution	1	Neir i	11	4b. City, Town, or Lo	January reation of Death		2006	1500
	Examir	ier	Future Care I		561)		Lochear		-		2 City
	Funeral		5. Social Security Number	6. Sex 7	. Age (In yrs. last birth	nday) If Under 1 Y		8. Date of Birth (Month, Day			ece (State or Foreign
	Director		219-28-4274	1□XM 2□ F	73 Y	rs.	eys Hours IVIII.	Jan. 10	,1933	Count	" MD
	land		Usual Residence of Decedent  10e. Stete 10b. Count	y	10c. City, Town	or Location				10	d. Inside City Limits
	Mary	tor	MD Ced	cil	Port D	eposit					1 ☐ Yes 2 🕱 No
	or 28	Direc	10e. Street and Number			10f. Zip Co	de	1	I0g. Citizen of V	Vhat Count	ry?
	ath w	ral	904 Hopewell			2190			USA		
20	permit. Pages 1 end 2 should be filed within 72 hours efter death with the Maryland Depertment of Health end Mental Hygiene. Important: If Item 27 is marked other than 'natural', or items 23a or 28a-f show any injury or other traumatic event, I're Modical Examiner must be notified at once.	y Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Ma  3 ☐ Widowed 4 ☒ Divorce	rried 1/1 Yes 2	□No	13. Was Decedent If Yes, specify  1 Yes 2	of Hispenic Origin? (Sp. Cuban, Mexican, Puerto No Specify:	ecify Yes or No- Rican, etc.)		e - America ck, White, e	tc.
Ş	tural'	ed b		d Year or Det nt's Education	16e [	Decedent's Usuel O	ccupetion		16b. Kind of Bu	usiness/Indi	
21215-0020	within 72 lene. than *ne the Medic	Completed by	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-4		'Give kind of work d life. DO NOT use re	one during most of work etired)	ing	TOD. FAILE OF DE	30110001110	2007
	filed wit Hygiene ther the	Com	12			ly & Fende	er Mechanic		Auto Bo		гор
Maryland	be fill d oth	Be	17. Father's Name (First, Middle				18. Mother's Name		Meiden Surnam	16)	
1	d Men marka matic	ျှ	Harry E. Weir 19a. Informant's Name/Relation		10h	Mailing Address (S)	Malva B		City of Town	Shoto Zin (	Codo)
Ma	end 2 s salth en n 27 is i		Jeryl McCarde				ll Road, Po		-	2190	
re,	other		20a. Method of Disposition		20b. Place of I	Disposition (Name of crematory or other			20c. Location -		
Ë	Pages nent of I int: If ite iry or of	1	1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (		ate	d Cemete		2-03-06	Oxford	, PA	
Baltimore,	permit. Depertuimporta any inju		21. Signature of Funeral Service	Licensee	A		ddress of Facility R.				ne, P.A.
ш	20 E # 9		Lichard	L. Go	o die	111 S. 9	Lueen Stree	t, Risir	ıg Sun,	MD 2	21911
		1 13	23a. Parti. Enter the disease, or shock, or heart failure. Lis	r complication that cau t only one cause on eed	used the death. Do no ch line.	ot enter the mode of	dying, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final			.	^			1	Onset and Death
	Examiner		disease or condition resulting in death)	a	Due to (or as a	ivation	presmon			<u> </u>	1 hour
	P #	ner			Due to (of as a go	onsequence oi <sub>j</sub> .	4				
	ficete be executed physician end ss the bural-transit	Examiner	Sequentially list conditions, if any, leading to immediate	<b>f</b> b.	Due to (or as a co	onsequence of):					
68760,	be ey	E L	cause. Enter Underlying Cause (Disease or injury that initiated events	С							
687		edical	resulting in death) Last	1	Due to (or as a co	nsequence of):					
Box	leath certifi ettending I for use es	M/u		d							
	law requires that the death cent es been signed by the ettending s 2 should be deteched for use o	Physician/M	Part II. Other significent conditi	ons contributing to deal	th but not resulting in	the underlying cause	e given in Part I.	23b. Did to	obecco use cor	ntribute to	the cause of deeth?
P.0	at the d by the							1 □ Y	es 2 No	3 Probe	ably 4 Unknown
	ires that signed t d be det	l by						04-144		Odb Wor	e autopsy findings
SOL	v require been si should	letec						24a. Was a perfor	med?	avai	lable prior to pletion of cause
Re	The law ate hes page 2	Completed						1 🗆 Y	es 242 No		eeth? Yes 2□ No
of Vital Records,		Be Co	25. Was case referred to medica	al			26. Place of Deatl			10	Yes 2   No
Ž	Physicien: rthis certific rral director,	ToB	examiner? 1 ☐ Yes 2 号 No	Hospital:	patient 2 ER/Outp	patient 3 DOA	Other:	me 5 Reside		er (Specify)	
0 0	Attending Phist death. ector: After this by the funeral	:uo	27. Manner of Death 1 ₩ Natural 5 Pendi	28e. Date of (Month,			Work?	28d. Describe h	ow injury occurr	ed	
Sio	or Attending Faffer death. Director: Affer in by the funer	Icati	3 ☐ Suicide 6 ☐ Could		Flaium. At hama form		1 Yes 2 No	28f. Location (Si	tract and Numb	or or Pum!	Pouto Number
Division	5 # # E	Certification:	4 ☐ Homicide determ	nined 286. Place of building	f Injury - At home, farr , etc. <i>(Specify)</i>	ir, street, ractory, on	ice	City or Town		er or nurar	noute Number,
	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune	edical C	29a. Certifier (Check only one)  12 Certifyli 2 Medical	ng Physicien: To the be Examiner: On the basi and manne	is of examination and/	death occurred at the	e time, date and place, ny opinion, death occurr	and due to the c ed at the time, d	ause(s) and ma ate and place, a	nner as sta and due to t	ted. the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certific			29c. Lic	cense number	2	9d. Date signe	d (Month, D	ay, Year)
				> -			737573		Januar	y 31,	2006
2	ZTIVA		30. Name and address of person	who completed cause	of death (Item 23a) (T	ype, Print) St, Re	isterstan	MD	21136	1	
	Sta Registr	201	31. Date filed (Month Pay Year	1 2006 32. 8	istrar's Signature	Sparke	137513				

DHMH 16 Rev 6/95

			1 - For State Registrar	State of N	1arylan	-	artmen rtificat					Reg. No	11116	) [	) 4, 4, 74,
	Physici	an	Decedent's Name (First, Midd							2	. Date of Di Month	eath Da	y Y	ear	3. Time of Death
	/Medi		Edith	Wright							anua	_		000	РМ
	Examir	ner	4a. Facility Name (If not institution 2002 E. Mar 1 h	-	r)				Location of [	Death		40	. County of		
	Eumanal		5. Social Security Number		ae (In vrs.	last birthday)		ndov 1 Year	er If Under 24	Hrs. 8	. Date of Bi	irth	PG		ace (State or Foreign
	Funeral Director		578-22-5946	1□M 2□F	8		Months			Min.	(Month, D	ay, Year,		Count	ace (State or Foreign try) DC
	p _		Usual Residence of Decedent						1		2 30		IO Wa	SII.	
	arylar show	-	10a. State 10b. County	PG	10c. Cit	ty, Town or Lo		ando						10	Od. toside City Limits
	he M	Director							ver						Yes 2 No
	with I	ä	10e. Street and Number 2002 E. Mar1b	oro Azzo			10f. Zip		705			10g. Ci	tizen of Wha	at Count	try?
	leath	Funeral	11. Marital Status	12. Was Deceder	nt Ever in U	.S. 13.1	Was Deced		785	n? (Specif	v Yes or N	0-	USA 14. Race -	America	an Indian
ယ	or iter	E	1 ☐ Never Married 2 ☐ Mar	Armed Forces	?				spanic Origin n, Mexican, F	uèrto Ric	can, etc.)		Btack, 1		
5-0036	72 hours after death with the Maryland natural', or items 23a or 28s-f show dical Examinar must be notified at	i by	3€3Widowed 4 □ Divorced	If Yes, Give Year or Dates	:		1 🗆 Yes	2 by No	Specify:				Specify:	В1	ack
5-0	72 h 'natu	Completed		nt's Education est grade completed)		16a. Dece	dent's Usua kind of wo	al Occupa rk done di	tion uring most o	f working		16b. k	ind of Busin	ess/Ind	ustry
2121	filed within Hygiene. Ither than "	mp	Elementary/Secondary (0-12)	College (1-4o	r 5+)	Super	oo noru: visc	se retired) or G	ov't	Pri	ntin	Q.	Gove	rnm	ent
d 2	filed Hygie ther			, Last)					18. Mother's			Ĭ			
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Marylan at of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumatic event, the Madical Exaperactions to collect and the routlest at	To Be	17. Father's Name (First, Middle, John S.	Miller					Eliza			_	iith		
ary	should and Men marke umatic	-	19a. Informant's Name/Retation	ship (Type, Print)		19b. Mailir	ng Address	(Street a	nd Number o	or Rural F	Route Numb	per, City	or Town, Sta	ite, Zip	Code)
_	and 2 lealth a m 27 is		Juleta Contee	/ Grandau	ghter	2002	E. M	lar1	boro	Ave	., La	ando	ver,	MD	20785
<b>Baltimore</b> ,	permit. Pages 1 and. Department of Health Important: If Item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		20b. F	cametery, crem	sition (Nan	ne of		Date		1	ocation - Cit		
Ē	Pag ment ant: i		`4 □Donation 5 □Other (S		Lir	nco1n	Memo	ria		-30		5	uit1	and	, MD
Salt	permit. Pag Department Important: I any Injury c		21. Signature of Funeral Service	Licensee	-	22	. Name an	d Address	s of FacilityR	ona	ld Ta	ay1c	r II	Fu	neral
	0.D.E & Q		malo	c con	711		1583	Mid	dlepo	rt ]	Lane	Whi	te P	lai	ns, MD
	. U.		23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final		1				, such as ca	rdiac or r	espiratory a	arrest,		1	Approximate Interval Between Onset and Death
7	Physician /Medical		disease or condition resulting in death)	Due to (or a		<del></del>	Stag	e							
	Examiner					30.100 01).									
	φ # g	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	s a conseq	uence of):									
	cate be executed physician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C											
8760,	be ex ician burial	al E	,	Due to (or a	is a conseq	uence or):									
687	icate phys s the	dlcal		d											
Box (	Jeath certifica attending ph I for use as th	Physician/Me	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom									23d. Date o	f deliver	v
	death e atte d for	Iclai	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	at time of d		Ectopic pr Other (sp						Month		Day Year
P.O.	that the death cer ed by the attendir detached for use	hys	9 Unknown	9□ Unknown											
	requires that the death certific een signed by the attending p hould be detached for use as	by P	Part II. Other significant conditi		but not res	ulting in the u	nderlying c	ause give	n in Part I.						e cause of death?
ord	w requir been si should	ted	Hypothyroidi	sm						_	10	Yes 2	□*No 3[	Proba	ably 4 Unknown
Records,	aw as b 2 sl	Completed by	Altzheimer's	Dementia							24a. Was	psy	prio	r to com	sy findings available
E H	Th page	Con									1 Tes	ormed?	dea		2□ No
of Vital	Physician: The this certificate har all director, page	Be	25. Was case referred to medical examiner?	Hospital:				Otho	26. Place of						
	Phys rthis ral di	- To	1 Yes 2 No 27. Manner of Death	1 🗆 Inpa		ER/Outpatier		/A	4   Nursi				6 Other (	Specify,	)
on	th. : After funer	tlor	1 Natural 5 Pendi	28a. Date of In (Month, E	ay Year)	Injury	М	8c. Injury Work' 1 □ Y	? es 2∐No		a. D0001100	now wite	ry cocarrou		
Division	f or Attendii after death. Director: Ai in by the fu	Ifica	3 Suicide 6 Coutd	nined 286. Place of I	njury - At h	ome, farm, str	eet, factory	r, office		28f	. Location	(Street ar	nd Number o	or Rurai	Route Number,
Ö	s after al Direct of in by	Certification:	4 O Hollicida	building,	etc. (Specif	Y)					City or To	wn, Stati	e)		
	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		(Check only 2 Medical	ng Physician: To the best Examiner: On the basis	of examina	owledge, death	occurred vestigation	at the time	e, date and p	olace, and	due to the	cause(s	) and manne	er as sta	ited. the cause(s)
	To the within 2. To the tomplet	Medical	one) 29b. Signature and title of certifity	and manner	stated.			. License					te signed (A		
	F 3 F 8		1 June	altrest-	WiM.	ILAR P		280					30,	20	
0	(0)		30. Name and address of person	who completed cause of	death (Iten	n 23a) (Type					•	- all	30,	20	00
K	(10)		Francine Higg					110	Dr #	100	, Be	ltsv	ille	, M	D 20705
	Sta	ate	31. Date filed (Month, Day, Year	<ul> <li>32. Regis</li> </ul>	trar's Signa	ature-	_ <u> </u>	-116	Ų.Į.						
	Registi	rar	FEB <b>€</b> 1 2	006 Section	1	A STATE OF									

			1- For State of Maryland	/ Department of Health and Certificate of Death		2006 044 /5
*	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, Last)  4a. Facility Name (If not institution, give street and number)	1 / 11/	January	Day Year 3. Time of Death 4:54 A M 4c. County of Death
	Funeral Director		1919 Brooks Drive #101  5. Social Security Number 6. Sex 1 □ M 2 ▼ F 95  Usual Residence of Decedent 7. Age (In yrs. las	Capitol Heigh it birthday)  Yrs.  Capitol Heigh If Under 1 Year If Under 24 Hrs  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	Prince George's  9. Birthplace (State or Foreign Country)  1910 Virginia
	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23e or 28e-1 ahow injury or other traumatic event, tre Medical Exertional to Incillical at 9.	Director		Capitol Heigh		10d. Inside City Limits 1 □ Yes 2 □ No Citizen of What Country?
	er death wit items 23e o	Funeral D	1919 Brooks Drive #101  11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?	20743  13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puent	pecify Yes or No- o Rican, etc.)	United States  14. Race - American Indian, Black, White, etc.
2-0030	2 hours afte hatural, or l	þ	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1 ☐ Yes 2 No Specify:	16h	Specify: African American Kind of Business/Industry
7	filed within 7 Hygiene. other than "n ent, It e Med	Completed	(Specify only highest grade completed)  Elementary/Secondary (0·12)  College (1-4or 5+)  4  17. Father's Name (First, Middle, Last)	(Give kind of work done during most of worldife. DO NOT use retired)  Federal Employee	king	Government
aryland	2 should be fi and Mental H is marked ot reumatic ever	To Be	Robert Winkey	18. Mother's Nan 19b. Mailing Address (Street and Number or Ru	(Unknow	m)
ore, Ma	es 1 and 2 of Health a f Item 27 is r other trai		John Robinson / God-son	5610 Shawnee St., E se of Disposition (Name of letery, crematory or other place)	orest Heig	
Банттог	permit. Pages 1 and Department of Heall Important: If Item 2 any injury or other 2005.			Lincoln Cemetery 1/28 22. Name and Address of Facility	tewart Fun	eral Home
	Physician		23a. Part. Fer the disease, or complications that caused in death. I shock, i heart failure. List only one cause on each line.  Immediate laise (Final disease or condition resulting in death)  Pansinus resulting in death)			Approximate Interval Between Onset and Death
,00700,	/Medical Examiner  bhysician and ithe burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequent cause).  Due to (or as a consequent cause).  Due to (or as a consequent cause).  Due to (or as a consequent cause).	on of Facial Sinuses		
O. BOX C	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  On the Funeral Director: After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 4 ☐ Pregnant at time of death 9 ☐ Unknown	ath 3 Ectopic pregnancy		23d. Date of delivery Month Day Year
U (Spilo	equires that en signed b	by	Part II. Dther significant conditions contributing to death but not resultin	ng in the underlying cause given in Part I.		o use contribute to the cause of death?  2   No 3 Probably 4 Unknown
מו חמני	Physicien: The law n this certificate has be al director, page 2 sh	e Completed	Advanced Age  25. Was case referred to medical		24a. Was an autopsy performed?	
<u> </u>	ysicia s certi directo	0 8	examiner?  1 Yes 2X No Hospital: 1 Inpatient 2 ER/	Oth	th (Check only one)	C DONA (Casaita)
	I or Attending Phatter death. Director: After thi	sation; T	27. Manner of Death 12 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day Year) 28	b. Time of Injury at Work?  M 1 Yes 2 No	28d. Describe how in	
2	pital or Att ours after do eral Direct filled in by t	i Certification;	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury · At home building, etc. (Specify)  29a. Certifier  1 ☐ Certifying Physician: To the best of my knowled.		City or Town, Sta	
	To the Hospital within 24 hours a To the Funeral completely filled	edical	29a. Certifier (Check only one) (Check only one)	age, death occurred at the time, date and place, and/or investigation, in my opinion, death occur	and due to the cause red at the time, date a	(s) and manner as stated.  nd place, and due to the cause(s)
	To the To the complet	Me	29b. Signature and title of certifier	29c. License number D36505		January 27, 2006
	(2)		30. Name and address of person who completed cause of death (Item 23 Eunice Shakir, M.D. 6104	a) (Type, Print) Old Branch Ave., Temp)	le Hille 1	MD 20748
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	_		20740

ORIGINAL

			F	State of Mar			t of Health		-		_	•
			1 - For State Registrar				e of Death		•	Reg. No.	000	04477
	Physici	20	1. Decedent's Name (First, Middle, La	•					2. Date of Dea			3. Time of Death
	/Medic		Margaret Virginia		er Wagner	_	<del></del> .		Februa	ry 2	, 2006	9:15 A M
	Examin	er	4a. Facility Name (If not institution, give				Town, or Location	of Death			County of De	eath
-	Funeral		8991 Rock Lodge Ro 5. Social Security Number 6. S		(In yrs. last birthda	Accid		r 24 Hrs.	8. Date of Birt	th	arrett	Birthplace (State or Foreign
ı	Director		214-34-1494	□M 2 <b>⊠</b> F	70 Yrs.	Months	Days Hours	Min.	(Month, Da) July 31	v, Year)		Country)  aryland
	pug *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location			-			•
	Maryla f sho	ō	MD Garrett		Accident							10d. Inside City Limits 1 ☐ Yes 2 🛣 No
	r 28a-	rect	10e. Street and Number		Accident	10f. Zip	Code			10g. Citi	zen of What	Country?
	h with	Funeral Director	8991 Rock Lodge Ro	ad		211	520			USA		,
	ems	ıner	11. Marital Status	12. Was Decedent Ev Armed Forces?	rer in U.S. 13		dent of Hispanic O	rigin? (Spec	city Yes or No-	-	14. Race - Ar Black, W	merican Indian,
99	s afte	by Fu	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:		1 🗆 Yes			,			hite
215-0036	be filed within 72 hours after death with the Maryland tial Hygiene. Ad other than "natural", or items 23a or 28a-f show event, the Medical Examination invalible indiffed at	ed t	15. Decedent's Ed	ducation	16a. Dec	edent's Usua	al Occupation			16b. Ki	nd of Busine	
2 2 2	within 72 lene. than "m	Completed	(Specify only highest gra	de completed)  College (1-4or 5+)	(Giv	re kind of wor DO NOT us	rk done during mo se retired)	st of working	9	, , , , , , , , , , , , , , , , , , , ,		
7	filed wil Hygien Ather th	Con	12		Owner	/Opera						Agency
and and	be fill be fill be fill be fill be fill be bed of the b	Be	17. Father's Name (First, Middle, Last)  Lawrence Brennema						(First, Middle,		Sumame)	
Maryland	should and Men marke umatic	2 C	19a. Informant's Name/Relationship (		19h Ma	iling Address	(Street and Numb		dwater		r Tourn State	Zin Codo)
	d 2 Tris		James A. Wagner/H				Lodge Ro					_
Z.	es 1 an of Heal ritem 2 rother		20a. Method of Disposition	10	20b. Place of Dis			Da				or Town, State
	permit. Pages Department of I Important: If it any injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐  '4 ☐ Donation 5 ☐ Other (Specify		Bittinge	er Cem	etery	Feb. 6	5, 200	Bit	tinge	r, Maryland
gall	permit. Departr Imports any inj		21. Signature of Funeral Service Licer	see		22. Name an	d Address of Facil	lity New	man Fu	nera	1 Home	es, P.A.
	40 = 6 Q	Щ	23a Parti Enterena dispassa or dom	plications that caused th			ox 275, G				21536	
	N		23a. Part1. Enter the disease, or dom, shock, or healt failure. List only Immediate Cause (Final									Approximate Interval Between Onset and Death
ľ	Physician /Medical		disease or condition resulting in death)		NO Cav	CIN	once		0 100			2 years
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	Da is	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence of):						-	
	xecut and al-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a	consequence of):							-
3/60,	death certificate be executed e attending physician and id for use as the burial-transit	calE		d	, , , , , , , ,							
9	rtificat ng phy as the					_						
Š R	leath certifica attending ph 1 for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2		□Ectopic pr	egnancy			2	23d. Date of c	
	he dez the al	Physician/Med	1 Yes 2 No	4□Pregnant at tir 9□ Unknown	me of death 5	Other (sp	ecify)			į	Month	Day Year
7	w requires that the debe signed by the should be detached		Part II. Other significant conditions c	ontributing to death but	not resulting in the	underlying ca	ause given in Part	I.	23e. Did to	obacco u	se contribute	to the cause of death?
cords,	quires n sign uld be	ed by							1 🗆 Y	res 2	<b>X</b> No 3□	Probably 4 Unknown
ဝ၁	law re as bee 2 sho	Completed							24a. Was		24b. Were	autopsy findings available
Ĭ,	The ate he	E O							autop perfor	med?	death	o completion of cause of ? es 2 □ No
, ital	yelcien: The law is certificate has t director, page 2 s	Be	25. Was case referred to medical examiner?					e of Death (	(Check only o		I	
0	y sign	2	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient				ursing Home	e 5 Resid		Other (Sp	pecify)
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5	rtal or rs afte rel Dire											
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	ro the within 2 Fo the complet	Mec	29b. Signature and title of certifier	and manner state	a.	29c	. License number			29d. Date	e signed (Mo	nth, Day, Year)
1	->-0		P Ando	mole	20		H2615	54		1	12/0	، حاد
			30. Name and address of person who	completed cause of dea		, Print)	2010	N		\ \		pakland
			31. Date filed (Month, Day, Year)	ller		9 4	2016	Ha	es 1	ンク	ive	MD ZISS
	Sta Registr		S1. Date filed (Month, Day, Year)	32. Registrar's	a Signature	Mondo	R a					

			1 For State	State of	Marylar		artmen			and Me	ental Hyg	giene	2006	01.1.78	
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cel	uncau	e oi L	Jeani	1	2. Date of Dea	Reg. No	000	3. Time of Death	_
	Physici /Medi		Delores Elizabe	th Willia	,						Month	Da 26	y Year 2006	м	
	Examir		4a. Facility Name (If not institution, gi				4b. City,	Town, or	Location o		lanuary		County of Deat	15:46P	_
			Suburban Hospit					Bethe					Montgon	iery	
	Funeral Director			Sex 7. 1 ☐ M 2 🗽 F	. Age (In yrs.	last birthday) Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day	, Year)	Co	hplace (State or Foreign nuntry)	1
			579-40-4400 Usual Residence of Decedent		/	/4	ll				May 3,	193	1 Wash	ington,DC_	
	arylan show	_	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Me Mi	ecto	Maryland Montgo	nery		Ве	these							1 ☐ Yes 2 ☐ No	
	with t	Funeral Director	10e. Street and Number				10f. Zip	Code			1	10g. Cit	izen of What Co	untry?	
	ne 23	era	10250 Westlake D:	rive Apt		J.S. 13. V	Was Deced	2081		in? (Spec	rify Yes or No.		USA 14. Race - Ame		
9	or iter	Fun	1 Never Married 2 Married	Armed Forc	es? ⊠No	'	_			Puerto R	cify Yes or No- lican, etc.)		Black, White		
9	Jral',	d by	3 ☐ Widowed 4 ★ Divorced	If Yes, Give Year or Date	es:		1□Yes 2	ZIKI NO	Specify:				Specify: Wh	ite	
<u>5</u>	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f ahow ta Madical Examiner must be netitied at	Completed	15. Decedent's E (Specify only highest gi	ducation ade completed)		16a. Deced		k done d	uring most	of workin	g	16b. K	ind of Business/	Industry	
12	iene. than	omp	Elementary/Secondary (0-12)	College (1-4	or 5+)			,				n 1			
פַ	il Hygi other	Be C	17. Father's Name (First, Middle, Las	1)		Baker	у ман	0	-	r's Name	(First, Middle,		ery Sumame)		_
/lar	should be ind Mental imarked c	ToE	Louis Boswell	L					Eli	zabe	th T	[av1	or		
Maryland 21215-0036	2 sho		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address	(Street a	nd Number	r or Rurai	Route Number	, City o	r Town, State, Z	(ip Code)	
e,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23s or 28s-f ahow amy privant: If item 27 is marked other than "natural; or iteme 23s or 28s-f ahow amy jury or other traumatic avant, the Medical Examiner must be notified at once.		James T. Willis, 20a. Method of Disposition	Jr.	Son	3654 Place of Dispo	Bel P	re 3	oad, A	pt.	34 StJ	ver	Spring	MD 20906	_
o D	Pages nent of ant: If its		1 ⊠ Burial 2 ☐ Cremation 3 [			cemetery, cren klawn 1	natory or of	ther place	. !				cation - City or	,	
Baltimore,	ortan Sartme	H	4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice	-		Park			Ja s of Facility	n.30	,2006 _	Roc	kville,	Maryland	_
ä	Departi Departi Import any in	8 9	I their Stiles			Fr 50	ancis O Uni	J.	Colli	ns F	uneral	Hom	e, Inc.	MD 20901	
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that cau	sed the deat	h. Do not ente	er the mode	of dying	, such as c	ardiac or	respiratory arri	est,	Phiring	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	a Colo		DER	FOR	<b>АТ</b> І	oN					Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or	as a conseq	uence of):	-1-10								_
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	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			ULITIS	<u> </u>								
ó	exec en an	Exa	resulting in death) Last	U	as a conseq										
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ی ×	ertific	Med	IF FEMALE:		U.S. 12							-1-			7
Вох	eath certific attending p	Physiclan/Me	23b. Was decedent pregnant in the past 12 months?		1 2 ☐ Feta	Ideath 3	Ectopic pre					2	23d. Dale of delin	very Day Year	
P. O.	res that the de igned by the a be detached f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	9☐ Unknow	t at time of d	eatn 5∐	Other (spe	ecify)							
ري. م	s that ned b e deta	by Pi	Part II. Other significant conditions	contributing to deat	h but not res	ulting in the un	derlying ca	use giver	n in Part I.		23e. Did tob	acco u	se contribute to	the cause of death?	_
Vital Records,	v require been sig should b	edr									1 ☐ Ye	s 2)	No 3□Pro	bably 4 Unknown	
မင္ပ	law requies been	Completed									24a. Was ar		24b. Were aut	topsy findings available ompletion of cause of	_
<u>~</u>	: The lay cete hes page 2:	So									perform	ned?	death?	2□ No	
<u> </u>	Attending Physician: The rideath.  ector: After this cardicete by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital: 1,  √				Other	100000000000000000000000000000000000000		Check only on				
Division of	Phy ar this aral di	٠ <u>.</u> آ	1 ☐ Yes 2 ☐ No 27. Mapner of De th	28a. D te of I	njury	ER/Outpatient 28b. Time of			4   14013		d. Describe ho		Other (Spec	ify)	_
<u>o</u>	death. ctor: After y the funer	ato	1 Natural 5 ☐ Pending 2 Accident investigatio		Day Year)	Injury	М	c, Injury a Work?	es 2□N				, 0004.104		
<u>                                      </u>	or Atta after de Directo in by th	Certification:	3 Suicide 6 Could not be determined	286. Place of	Injury - At ho	ome, farm, stre	et, factory,	office		28	f. Location (Str City or Town	reet and	d Number or Rui	ral Route Number,	
	Hospital or 14 hours afte Funeral Dir tely filled in	Se	<u> </u>									·			1
	To the Hospital or Ati within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier (Check only one)  1 ☐ Certifying Pt 2 ☐ Medical Exam	nysician: To the be niner: On the basis and manner	s ot examinai	wledge, death tion and/or inv	occurred a estigation,	t the time in my opii	, date and nion, death	place, an	d due to the ca at the time, da	iuse(s) ate and	and manner as place, and due	stated. to the cause(s)	
	within 2 within 2 To the I	Me	29b. Signature and title of certifier	110 1118111161	Stateo.			License					signed (Month,		
	1		> Alpango	war	17.0	, .	1	-2	766=	>			27/06		
		1	30. Name and address of perso who	completed cause of	of death (Item	1 23a) (Type, F	Print)					-	•		_
			Alpana Goswami,	M.D. 1:	1119 R	ockvil]	le Pil	ke #(	G100	Rock	ville.	Mar	71and 20	852	
	Star Registra		31. Date filed (Month, Day, Year) FEB 0 1	2006 32. <b>Rio</b> gi	strar's Signa	lute A	all s	in supple							

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 1:44P M 2006 27, Jules Waxenberg January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda
| If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Suburban Hospital Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 12, 9. Birthplace (State or Foreign Country) New York, NY **Funeral** 1፟፟፟፟M 2□F Director Yrs. 106-18-2301 80 Usual Residence of Decedent with the Maryland 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits items 23a or 28e-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Depertment of Health and Mental Hygiene. Importent: if Item 27 is marked other then "natural", or Items 23a or 28e-1 show any higher the arms of the arm 1 TXes 2 □ No Director Maryland Montgomery Chevy Chase 10e. Street and Number 10g. Citizen of What Country? 10f. Zio Code Funeral 20815 USA 8100 Connecticut Ave, #818 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 万 Yes 2 □ No If <del>Ye</del>s, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 反 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced WWII White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Gallo Wines 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ၉ David Waxenberg Rose Kirschman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5410 Trent St, Chevy Chase, MD 20815 Debra Rutenberg/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State I ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 30, 2006 Olney, MD Judean Memorial 21. Signature of Funeral Service License 22. Name and Address of Facility Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Sensis /Medical Due to (or as a consequence of): Examiner Staph Aureus Sequentially list conditions, it any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed use as the burial-transit **e**nd resulting in death) Last Due to (or as a consequence of) Box 68760, sicien Completed by Physician/Medical ettending phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death signed by the el d be detached for 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 CUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑Unknown <u>Heart Failure</u> peeu 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Renal Failure certificete 1 Yes 2 X No 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo 1 X Inpatient 2 ☐ ER/Outpatient 3□ DQA this To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral is 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 XNatural 1 Tyes 2 No 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 (X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medicai 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number January 28, 2006 D63195 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd, Bethesda, MD 20814 Dr. Stephen Wilks 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

FEB 01

2006

			1- State of Maryland / Department / Department / Departmen	artment of Health and Natificate of Death		enen () 6	04480
2	Dhusisi	d. Wy	Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year	3. Time of Death
7	Physici /Medic		AMERO KENNETH WARE			29, 2006	1:05 A M
4.0	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death	
	· ·	<u> </u>	Shady Grove Hospital	Rockville		Montgom	
100	Funeral Director		5. Social Security Number  490-70-3998  6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 46  Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Sept 28	rear)   Cou	place (State or Foreign intry) SSISSIPPI
	and and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryi 	jo	Md Montgomery Montg	gomery Village			1 √es 2 No
	1 the	Director	Md Montgomery Montgomery	10f. Zip Code	10	g. Citizen of What Cou	intry?
	h with		20006 Hob Hill Way	20886		II C 7	ľ
	deat	Funerai		Was Decedent of Hispanic Origin? (Splif Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	U.S.A. 14. Race - Amer	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Hall and Mental Hygiene. Introprent: If item 27 is marked other then "natural", or items 23a or 28a-f show eny injury, or other treumatic event, the Medical Exam har must be notified at once.	þ	1 ☐ Never Married 2 反 Married 1 ☐ Yes 2 反 No	1 ☐ Yes 2 <mark>1</mark> No <i>Specify:</i>	o Rican, etc.)	Specify: B1:	, etc. ack
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2	ed wi	Con	4 Yrs	Rehab Aide		Rehab (	Center
lud	d oth	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	aiden Sumame)	
<u>\Z</u>	Men Men Marka Marka	ဥ	Edward Parson	Peg	gy War	e	
Maryland	12 st h and 7 is n treun		19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	ng Address (Street and Number or Ru	ral Route Number,	City or Town, State, Zi	\$20886
e,	1 and Healt em 2 ther			0006 Hob Hill W	Date 2	tgomery ( Oc. Location - City or T	<u> Village, M</u>
Baltimore,	Pages ment of lent: if it		1 Rurial 2 Cremation 3 Removal from State cemetery, crem	of Heaven 2/3			oring, Md
Ball	Departimon Departimon imported in po			Snowden Funera 246 N. Washing			
1 3	79.		23a. Part 1. Enter the disease, or complications that caused the death. Oo not entreshock, or heart failule. List only one cause on each line.				Approximate Interval Between
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× 6	The law requires that the death certific tie has been signed by the attending p bage 2 should be detached for use as	- eo - i	IF FEMALE: 23c. If yes, outcome of pregnancy			2015	
Вох	atten for u	Physician/M	in the past 12 months?	Ectopic pregnancy Other (specify)		23d. Date of deliv Month	'ery Day Year
o.	at the de by the a tached	ysie	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Otto (specify)			
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rds	n sign	ed by			1 🗆 Yes	2 2No 3 Pro	bably 4 □Unknown
00	s been si should!	siete			24a. Was an	24b. Were aut	opsy findings available
Re	The tav	Completed			autopsy performe	ed?   death?	opsy findings available ompletion of cause of
ta		0	25. Was case referred to medical	26 Place of Dea	1 ☐ Yes 2 ☐	ZNo 1 ☐ Yes	2∐ No
<u>-</u>	Physici this cer al direc	ToB	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 FR/Outpatien	Other		ce 6 ☐Other (Speci	fv)
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<u>ö</u>	tendir leath. tor: Af the fu	atic	2 Accident investigation	M 1 Yes 2 No			
Division of Vital Records,		Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, streeth building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	et and Number or Rur State)	al Route Number,
	To the Hospital or Attend within 24 hours after death To the Funeral Director: 4 completely filled in by the f	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death control one and manner stated and manner stated.	n occurred at the time, date and place, restigation, in my opinion, death occur	and due to the cau	se(s) and manner as se and place, and due t	stated. to the cause(s)
	To the within 2 To the complet	Med	and manner stated.  29b. Signature and titted certifier	29c. License number		1. Date signed (Month,	
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	10		30. Name and address of person who completed cause of death (Item 23a) (Type, It	14	30	anuary d	1204
			Dr Michael Cetta M.D. 9901	· ·	מ אח א	/ Ockri 11 -	Ма
246	Sta	te	31. Date filed (Month, Day, Year) 32. Régistrar's Signature	Manual Cente	T DI, K	OCKATITE	, MG
1	Registr		31. Date filed (Month, Day, Year) FEB 0 1 2006 32. Régistrar's Signature	MARLI			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 2006 30, 2009 Ali Abdul Walii Jan. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 MM 2 □ F 61 14, Director 579-54-2154 1944 Washington, DC Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelth and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23s or 28s-f show any injury or other traumatic event, the Medical Exercites mant be trutified at any high youther traumatic event, the Medical Exercites mant be trutified at mones. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No Directo Maryland | Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8560 2nd Ave. #408 20910 United States Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Folces:

1 \( Yes 2 \) No

If Yes, Give
Year or Dates: \( Vietnam \) 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: Specify: Black Ž 3 ☐ Widowed 4 ☐ Divorced Completed 15. Oecedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Shipping Unknown Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be (Unknown) Barnes (Unknown, Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty Gilbert Walii-Spouse 8560 2nd Ave., #408, Silver Spring, MD 20910 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Slate 20a Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 □ Other (Specify) Jan.31,2006 Maryland National Laurel, Maryland 21. Signature of Fineral Service 22. Name and Address of Facility 933 Gist Ave.LL a Thibadeau Mortuary Service P.A. Silver Spring, MU Part 1. Ehter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Gastrointestinal Bleeding Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Hepatoma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a sonsequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien end hed for use as the burial-transit Exam Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Oate of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Hepatitis C Infection 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No Be 25. Was case referred to medical examiner? 26. Place of Oeath | Check only one Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury al Work? 28d. Describe how injury occurred Certification: After 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident efter death 6 ☐ Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral C 📧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and markier as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of #6 D45471 Jan. 31, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Yeheyis Negussie Spring St. #214, Silver Spring, MD 20910 1111 31. Date filed (Month, Day, Year) 32. Rigistrar's Signature State 2006 FEB 01 Registrar

Physician /Medical Examiner Funeral Director	1. Decedent's Name (First, Midd Alice Marie )						Reg. No.		
/Medical Examiner Funeral		COTINIC				2. Date of De		V	3. Time of Death
Examiner Funeral	4a Facility Name (If not institution	COUNG				Janua	ry 31,	2006	10:25 p <sup>M</sup>
		on, give street and numb	ber)	4b. City, Town, or			4c. Cour	nty of Death	
	118 East North				rstow			shing	ton
	5. Social Security Number 220–26–0468  Usual Residence of Decedent	6. Sex 7. 1 ☐ M 2 ☒ F	. Age (In yrs. last birthda 76 Yrs.	y) If Under 1 Year Months Days	If Under 2 Hours	Min.  8. Date of Bir (Month, Da Dec. 16	av. Year)	Cou	place (State or Foreign ntry) yland
show show	10a. State 10b. County	/	10c. City, Town or	Location					10d. Inside City Limits
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with the Ma	10e. Street and Number			10f. Zip Code			10g. Citizen o	f What Cou	ntry?
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be liled within 72 hours after death with the Maryland nat Hygiene.  ad other than "naturel", or Items 23e or 28e-1 show event, I're Marieal Exerciter must be notified at Be Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Mar 3 □ Widowed 4 🖾 Divorced	rried 1 Tyes 2	IX No	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☒ No	ispanic Orig in, Mexican, Specify:	jin? (Specify Yes or No , Puerto Rican, etc.)	Spec	ace - Americ lack, White,	
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12 sho h and 7 Is mu treume	19a. Informant's Name/Relations Dolly A. Lane					r or Rural Route Number			
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the Hosp in 24 hou the Fune ipletely fill	(Check only 2 Medicel one)	Examiner: On the basi and manner	s or examination and/or	nvestigation, in my op	inion, death	occurred at the time,	date and place	, and due to	the cause(s)
vithin 2 vithin 2 complet	29b. Signature and the of certifie		1	29c. License	number		29d. Date sign	ed (Month, I	Day, Year)
	1 leone	C. Theon	ran// MI	0001	750	. /	Fol	. 1	2001
	30. Name and ddress of person	who comple ed cause of	of death tem 23a) (Type 1110 Medic istrar's Signature	, Print)	101		7 6 6	- 9	2006
-5		umanIr. 1	1110 Medic	al Compus	et si	lite 130 h	tagers	town	MD217
State Registrar	31. Date filed (Month, Day, Year)		istrar's Signature	,		, ,	/		/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Registre MEDIA PARTITION FOR THE PROPERTY OF T Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Januar Jack 1850 Zuniga Jorge A. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** avoel Begional Hospital Prince Laurel Hospital Georges If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State of Foreign
Country) **Funeral** Months Days Hours Min 1XM 2□F Yrs Director 55 HONDURAS 578-70-9303 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow the Medical Examiner must be notified at 1 ▼ Yes 2 No Director MD. PRINCE GEORGES LAUREL 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 or Items 23a 8939 MATTHEWS CT. 20708 HONDURAS Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status e filed within 72 hours after of Hygiene.

Other than "naturel", or Itel 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1

Yes 2□ No Specify. δ 3 □Widowed 4 □Divorced HONDURAN WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) PAINTER 12 CONSTRUCTION permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Importent: If Item 27 Ie marked other t any injury of other traumatic event, III 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be **GEORGE** SR. ZUNIGA MARIA ANDINO ပ Α. Ι. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) GLADYS ZUNIGA/WIFE 8939 MATTHEWS CT., LAUREL, MD. 20708 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Washington, D.C. 20a. Method of Disposition Mt concin controcarie tosev l ☑Burial 2 ☑Cremation 3 ☑Removal from State CHAMBERS CREMATORY FEB. 3, 2006 -RIVERDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
CHAMBERS FUNERAL HOME & CREMATORIUM, P.A.
5801 CLEVELAND AVE., RIVERDALE, MD. 20737 21. Signature of Funeral Service Ligensee Chame M00091 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cartiovascular Heart Physician Atherosclerotic disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Tany, leading to imm adia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Box 68760 certificate be Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. the 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner's Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 □ DOA 1XYes 2 No 1 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death he Hospital or Attending Pl n 24 hours after death. he Funerel Director: After th 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation Injury 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the I within 2 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2

DHMH 17 Rev 1/2001

State

Registrar

Drive,

3001 Hospital

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

31. Date filed (Month, Day, Year)

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7 2	State	3	31. Date filed (Month, Day, Year)		gistrar's Signature	a		LI DI	DAI erun	TILOKE	, I'I	ימידידיאוארוי	ZIZUI	
Regi	istrar		FFR 1 6 200	G Ro	M.	Ace	Ke							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Ragistrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** ABCOCK FEBRUAR) 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE CITY HOPK, NS HOSPITAL The JOHNS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1□M 2√F Yrs. 63 223-52-1471 Director 9-26-42 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County in than "naturel", or Iteme 23e or 28a-f ehow the Madical Examiner must be notified at 1 ☑ Yes 2 ☐ No Director McHenry McHenry Il. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 60050 1104 Somersetmall Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 20 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Air Filtration Customer Service Rep. 12th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Mental is marked Ball Dills Opal 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) f Heelth McHenry, Il. 1104 Somersetmall, Jerry Heling 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Depertment of Important: If it eny injury or o ō 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-21-06 Woodstock, SMC Crematory 21. Signaruje of Funeral Service Licensee 22. Name and Address of Facility 21202 Baltimore, Md. 1101 E. North Ave. March F.H. East Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Days **Physician** EREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Days CASTROINTESTINAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit 3 Months LUNG CANCER The law requires that the death certificate be executed NON-SMALL CELL that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 No Day 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown ete has been signed by pege 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2☐ No 24a. Was an this certificete 2 No 1□ Yes To the Hospital or Attending Physicien: After this certific tuneral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide within 24 hours efter To the Funeral Dire 1) Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medica (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MEDICAL DOCTOR FEBRUARY 14, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 THE JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, BOLTIMORE MARYLAND 21231 PETER (PRY) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 11th 2006 Physician 6.46AM JAMES A. BARNETT /Medical 4c. County of Dealh 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore-Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Oate of Birth (Month, Day, Year) 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 179-28-2816 71 May 13, Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "naturel", or Iteme 23a or 28a-f ehow the Modical Examiner roust be notified at 1X Yes 2 □ No Funeral Director Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 313 Hospital Drive 21061 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2X No Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Oecedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9th none none Ø and 2 should be file and 2 should be file and 1 should be file and Mental Hyonent: If Item 27 is marked by or other training. Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edwin Barnett Hilda Hughs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Barnett/Daughter 8324 Deer Run Court, Severn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite eny injury or ott 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 22. Name and Address of Facility Donaldson Fig. 313 Talbott Avenue, Laurel,

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cay to on each line.

Immediate Cause (Final disease or condition resulting in death)

a. December 11-2/16/06 West Arundel Crem. Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 313 Talbott Avenue, Laurel, MD Approximate Interval Between Onset and Death Physician /Medical Examiner Squentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner anding physicien and use as the burial-transit Due to (or as a consequence of): Physician/Medicai ettending f IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) ed by the e Ö 9 Unknown 9 Unknown ate has been signed page 2 should be de Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Pulmonary Obstructive 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2/Z No 1 ☐ Yes 1 Yes Division of Vital : After this certifical funeral director. I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Tes 2 No within 24 hours after death.

To the Funstral Director: A completely filled in by the fu 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and litle of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) alen Burnie 7845 Dakwood Road K-Ambalavanar 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

			1 - For State Registrar	State of Mar		artment of F		d Mental Hyg	giene	16 04487	1
20	Physic /Medi		Decedent's Name (First, Middle, Last  JOHN	L L	3 RAND	7,5,	P.	2. Date of Dea		Year 9 - 004	
	Exami	ner	4a. Facility Name (It not institution, give baltimore V/4 Reh	ab & Exte	noted Care	4b. City, Town, o  Bal  If Under 1 Year	r Location of D	l	4c. Count		
23. 100. 100.	Funeral Director			M 2□F 8.	(In yrs. last birthday)  Yrs.	Months Days		Min. 8. Date of Birtl Month, Pay Nov. 4,	1920	9. Birthplace (State or Fore Country) Maryland	sign
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, tra Madical Exertical must ke muffled at 2006.	To Be Completed by Funeral Director	MD Baltim  10e. Street and Number  3620 Eitemiller  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest grave)  Elementary/Secondary (0-12)  8  17. Father's Name (First, Middle, Last)  John Parker Braves  19a. Informant's Name/Relationship (7-14)  John L. Brandt, J	Road  12. Was Decedent Ev Armed Forces? 1 May 2 Door No If Yes, Give Year or Dates:  ucation de completed)  College (1-4or 5+)	16a. Dece (Give life.) Self I	Te  10f. Zip Code  21244  Was Decedent of H If Yes, specify Cubz  1 Yes 2 No  dent's Usual Occup kind of work done  DO NOT use retired.  Employed	ispanic Origin' an, Mexican, P Specity:  ation during most of in Exce 18. Mother's Alice	? (Specify Yes or No- uerto Rican, etc.)	14. Ran Bla Specific		
Baltimore, I	permit. Pages 1 and Department of Health Important: If Item 27 any injury or other t		20a. Method of Disposition  1. Burial 2 Cremation 3 4 Donation 5 Other (Specify 21. Signature of Funeral Service Licen	Removal from State	20b. Place of Dispo cemetery, cren LakeView	sition (Name of natory or other place  Memoria  Name and Address	ne)   1 Pk Fe	Date 2006	Sykes	City or Town, State ville, MD Directors, I	nc
8760,	Physician and Medical Examiner transit	dical Examiner	23a. Parti Criter the disease or composition shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)  Scoundfally fist conditions if any, leading to immediate cause. Enter Underlying Cause (Oisease or injury that initiated events resulting in death) Last	a	consequence of):	er the mode of dyin	g, such as carr	diac or respiratory arr		Approximate Interval Between Onset and Death	
.O. Box 6	that the death certific ed by the attending pl detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 I 4 □ Pregnant at tin 9 □ Unknown	☐Fetal death 3 ☐	Ectopic pregnancy Other (specify)				te of delivery inth Day Year	
al Records, P	The law requires ate has been sign page 2 should be	Completed by	Part II. Other significant conditions on CHROMIC OF DISEASE	ontributing to death but n	not resulting in the ur	nderlying cause give	en in Part I.	24a. Was a autops perform	n 24b.	ribute to the cause of death?  30 Probably 4 Unknow Were autopsy findings availate prior to completion of cause of death?  1 Yes 2 No	wn
Division of Vital	Attending Phys ar death. ector: After this by the funeral did	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined	Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Y) 28e. Place of Injury building, etc. (	28b. Time of Injury	28c. Injury Work M 1 🗆 Y	Nursin	Death Check only on g Home 5 Reside 28d. Describe ho 28f. Location (St City or Town	ence 6 Oth		
)	To the Hospital or within 24 hours afte To the Funeral Dirt completely filled in the Tomber or completely filled in the Tomber or the Tomber o	Medical C	29a. Certifier (Check only one)  15 Certifying Phy 2 Medical Exam  29b. Signature and title of perifier	rsician: To the best of r iner: On the basis of ex and manner stated	tamination and/or inv	occurred at the timestigation, in my op	oinion, death of	courred at the time, di	ate and place,	and due to the cause(s)  If (Month, Day, Year)	
	<i>9</i> Sta Registr		30. Name and ad s so of person whole 3900 Local 31. Date filed (Month, Day, Year)	ompleted cause of deat  Raver  32. Registrar's	n Bh	Print) XIA	NIRO BAL	timore	Te, m	014, roo	7

yland 21215-0036

1 - For State Registrar

**Physician** 

/Medical

Examiner

**Funeral** 

Director

'neturel', or Items 23a or 28a-f show dical Examiner must be notified at

Director

To Be Completed by Funeral

death with the Maryland

ould be filed within 72 hours after on Mental Hygiene. Rerked other then "neturel", or Iter

Baltimore, Mar	permit. Pages I and 2 sh Department of Health and Importent: If item 27 Is and any injury or other treum once.		19a. Informant's Name/Relationship (Ty  20a. Method of Disposition 1	Naughkk Removal from State Do Bee MO1455	Place of Disposition permetery, crematory  WYICW  22. Nam  22. Nam	or other place)  (emotibly   2 / 1,  a and Address   Facility  (a d ley - As  134 W 110 W	Harford Date 17/04 Lton SDr.
,09.	Medical /Medical Examiner	al Examiner	23a. Part1. Enter the disease, or complished, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause final and the cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect	ONIA :(a soneup YASL quence of):	node of dying, such as cardia	c or réspirat
Division of Vital Records, P.O. Box 68760,	To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medical	in the past 12 months?  1 ☐ Yes 2 ☒ No 9 ☐ Unknown  Part II. Other significant conditions con		al death 3 ☐ Ectopi death 5 ☐ Other sulting in the underlyin	ig cause given in Part I.	239.
tal Recorc	en: The law requi	Be Completed	END STAGE RE			(SEASE	24a.
of Vi	g Physici er this cer eral direci	2	examiner? 1 ☐ Yes 2 ☑ No  27. Manner of Death	28a. Date of Injury	28b. Time of	26. Place of De  DOA Other: 4 Nursing I	
Division	To the Hospitel or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Certification:	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	(Month, Day Year)  28e. Place of Injury - At h building, etc. (Special	Injury M ome, farm, street, fac	Work? 1 ☐ Yes 2 ☐ No	28f. Locati City of
	To the Hospitel within 24 hours a To the Funeral I completely filled	Medical (	one)	ician: To the best of my known of the basis of examination and manner stated.	ation and/or investigat	red at the time, date and place ion, in my opinion, death occi	e, and due to
	P wit of S		29b. Signature and title of certifier			29c. License number	

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year ertrude 3.33 AM FEBRUARY 14 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Wonths Days Hours Min. (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1□M 212F 215-30-152/ Usual Residence of Decedent Yrs. MUDRY 21, 1935 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 502 12. Was Decedent Ever in U.S. Armed Forces? 21222 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WKIte 3 □ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electrical technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ANTHONY Falkenstein Maky Elizabeth Greeley and Number or Rural Route Number, City or Town, State, Zip Code) MD 21040 20c. Location - City or Town, State Baltimore, MD Funeral Home, P.A. ory arrest Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No autopsy performed? 2 🛛 No es' only one) Residence 6 Other (Specify) ribe how injury occurred ion (Street and Number or Rural Route Number, r Town, State) the cause(s) and manner as stated. ime, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RNOTON RES 000 FEBRUARY 14 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROHINI NORONHA, 56 OLLOCH RAVEN BLUD BALTIMORE, MD 21239 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

State

Registrar

32 Registrar's Signature

FEB 1 6 2006

			For State	State of Ma		artment of Hertificate of L		nd Mental Hy	2005	04489				
			1. Decedent's Name (First, Middle, Las	st)		Timoate of L	Journ	2. Date of Death						
	Physici /Medic		Ruth Er	telt Bri	ghtbill			Febru	February 11, 2006 7:25 A <sup>M</sup>					
	Examin		4a. Facility Name (If not institution, give		<u></u>	4b. City, Town, or	Location of	Death	4c. County of D					
			Laurel Regiona			Lau			Prince Georges  8. Date of Birth (Month, Day, Year) APR 6, 1921  Prince Georges 9. Birthplace (State or Foreign Country) New Jersey					
4	Funeral		5. Social Security Number 6. S	ex 7. Age □M 2XF	e (In yrs. last birthda) Q/, Yrs.	Months Days	If Under 24 Hours	Min. 8. Date of Bi	rth 9. 1 9. 1 9. 1 9. 1 9. 1 9. 1 9. 1 9.	Birthplace (State or Foreign Country)				
W.	Director		055-07-1689 Usual Residence of Decedent		84 Yrs.			APR 0	, 1921 Ne	ew Jersey				
	yland		10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits				
	a-fel	ctor	Maryland Prince	Georges	Lá	aurel				1 XYes 2 □ No				
	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What	Country?				
	ath w		7700 Cherry 1		- 4	207				USA				
	er de	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		. Was Decedent of Hi If Yes, specify Cuba	ispanic Origi n, Mexican,	n? (Specify Yes or Ni Puerto Rican, etc.)	0- 14. Race - A Black, W	merican Indian, hite, etc.				
36	irs aft	by F	1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ♠ ↑ If Yes, Give Year or Dates:	10	1 ☐ Yes 2 ☐ No	Specify:		Specify:	White				
21215-0036	within 72 hours after death with the Maryland ene. than "neturel", or iteme 23e or 28e-f ehow healtest Exertires must be notilled at	ted	15. Decedent's Ed	lucation	16a. Dec	edent's Usuaf Occupa	ation		16b. Kind of Busine	ss/Industry				
215	thin 7	Completed	(Specify only highest gra	College (1-4or 5	life.	e kind of work done of DO NOT use retired,	) most o	or working						
2	ed wi	Co	10		Ho	omemaker			Own Ho	me				
Maryland	be fil htal H bd ott	Be	17. Father's Name (First, Middle, Last)					s Name (First, Middle						
ž	hould d Mer mark matic	2	Carl Ertelt  19a. Informant's Name/Relationship	Type Print)	19h Mai	ing Address (Street a		arie Kipp	er, City or Town, State	Zio Code)				
<u>≅</u>	ith an		Richard Eugene Br			9 Veteran			•	11e, MD 21108				
ē,	f Healten		20a. Method of Disposition		20b. Place of Disc		1	Date	20c. Location - City					
Ê	Page nent o nt: If		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			ematory,		2/14/06	Baltimo	re, MD				
Baltimore,	permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importment of Health and Mental Hygiene. Importment: If tem 27 is marked other than "neturel, or iteme 23e or 28e-f ehow any injury or other traumatic event, the Medical Exeminer must be notified at once.		21. Signature of Euneral Service Licental A. Green	Trees lie	- 1				Society o					
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused	the death. Do not en	nter the mode of dying	g, such as ca	rdiac or respiratory a	rrest,	Approximate Interval Between				
	Physician		Immediate Cause (Final disease or condition		ricular	Fibrilla	tion			Onset and Death Minutes				
	/Medical Examiner		resulting in death)		a consequence of);	IIDIIII	CIOII			1.11.0300				
*	Lxammer		Sequentially list conditions,	b. Coro	nary Art	ery Dise	ase			Years				
1	led isit	nine	if any, feading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence or):									
	and al-tra	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequence of):									
8760,	icate be executed physicien and s the burial-transit	dlcail	(	d										
	tifical	Medi	15.55VIV.5											
Вох	death certific e attanding p od for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 mg/mths?	23c. ff yes, outcome 1 ☐ Live birth		□Ectopic pregnancy			23d. Date of Month	delivery Day Year				
о. П	0 00	sici	1 Yes 2 No	4 Pregnant at 9 Unknown	time of death 5	Other (specify)			MOITH	Day 16a1				
<u>ď</u>	that the ed by detect	Ph	Part II. Other significant conditions or	ontributing to death bu	it not resulting in the	underlying cause give	en in Part I.	23e, Did	obacco use contribute	to the cause of death?				
ds,	8 P. 9	d by	History of						./	Probably 4 Unknown				
S	w require been sign	lete						24a. Was	an 24h Were	autopsy findings available				
Be	he la e has age 2	Completed						auto perfe	psy prior death	o completion of cause of ?				
a	an: rtifice tor, p	0	25. Was case referred to medical				26. Place o	1 ☐ Yes f Death (Check only		es 2 No				
<b>\Sigma</b>	nysici lis ce direc	To B	examiner? 1 Yes 2 No	Hospitaf: 1 ☐ Inpatie	nt 2 ER/Outpatie	nt 31 DOA Othe	AC.		dence 6 □Other (S	Decify)				
0	ng Pt fter th		27. Manner of Death 1 Natural 5 ☐ Pending	28a, Date of Injur (Month, Day	y 28b. Time (	of 28c. Injury Work	at ?	28d. Describe	how infury occurred					
<u>sio</u>	death. ctor: A	cati	2 Accident investigation 3 Suicide 6 Could not be				res 2□No							
Division of Vital Record	after d Direct Jin by	Certification:	4 Homicide determined	28e. Pface of Inju building, etc	ry - At home, farm, s . (Specify)	reet, factory, office		28f. Location ( City or To	Street and Number or wn, State)	Rural Route Number,				
	To the Hospitel or Attending Physician: The law within 24 hours after death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	dical	29a. Certifier 1 Certifying Ph	ysician: To the best of iner: On the basis of and manner sta	examination and/or in	th occurred at the tim nvestigation, in my op	e, date and pinion, death	place, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)				
	To the within 2 To the complet	Me	29b. Signature and title of cartifier	1 m	All 1x	29c. License	number		29d. Date signed (Mo	nth. Day, Year)				
			moth	1:1116	Un M	1 73	953	52	02/12/	06				
	\$			completed cause of de	ath (Item 23a) (Type	, Print)	Canr.	, 61 ,	1	22717				
18	9		31. Date filed (Month, Day, Year)	1 Unn	19932 r's Signature	rince	ronge	. IT. La	use Mi	2010/				
1	Sta Registr		FEB 1 6 2	37	es A A	and a								

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year Jacques Brochu 4:40 PM M February 10, 2006 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deeth 3704 N. Charles Street #506 N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 9. Birthplace (State or Foreign Country) Canada 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral ™** M 2□F 81 Yrs. 266-66-8798 Director Aug 24, 1924 Usual Residence of Decedent 10a. State r 28e-f ehow 10b. Counts 10c. City, Town or Location 10d. Inside City Limits N/A 1 XYes 2 No Baltimore Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ item 27 is marked other than "naturel", or Itema 23a or other traumatic event, the Medical Examenations must be 3704 North Charles Street #506 21218 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced naturel Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Draftsman Air Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 UNK UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 33301 19a. Informant's Name/Relationship (Type, Print) Monique A. Brochu, Daughter 1 East Broward Blvd.Suite 700 Ft. Lauderdale, Fl Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Department Important: If any injury o \* 4 □ Donation 5 □ Other (Specify) Metro Crematory Inc. 02/15/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee
Thomas Gregor permit. Cremation Society Of Maryland Inc. 299 Frederick Road Baltimore, Mary 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician Cancer unknown Mon this /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): death certificate be executed burial-transit Exam and Due to (or as a consequence of): Box 68760. the attending physician hed for use as the burit Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached ☐Yes 2☐No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Division of Vital 1□ Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2□ No 2 this To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Yeer) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1-Natural 5 Pending investigation Injury death. 1 Tyes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funerel L To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

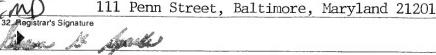
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D23076 2-15-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rul Saltimore Md 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 6 2006

				epartment of Health and l Certificate of Death	Mental Hygier	(UUb t	)4491
	Physici		1. Decedent's Name (First, Middle, Last)  Frank Eddie Batts		2. Date of Death Month February	Day Year 9.2006	3. Time of Death 5: 45am м
	/Medic Examir		4a. Facility Name (If not institution, give street and number) 4006 Beachcraft Court	4b. City, Town, or Location of Death Temple Hills		4c. County of Death Prince	eorge
	Funeral Director		2-14-20-43-13	day) If Under 1 Year If Under 24 Hrs Months Days Hours Min.	8. Date of Birth (Month, Day, Yea Jan.18,1919		lace (State or Foreign try) h Carolina
	f show	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  MD Prince George Temp1	or Location .e Hills		1	0d. Inside City Limits 1   Yes 2 □ No
	with the N Sa or 28a-1 Le notifi	i Director	10e. Street and Number 4006 Beachcraft Court	10f. Zip Code 20748	10g.	Citizen of What Coun	try?
036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural; or Items 23e or 28e-f show aumatic event, If a Madical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces? 1 See 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 Yes 2 Mo Specify:	pecify Yes or No- to Rican, etc.)	14. Race - Americ Black, White, Specify: B1a	etc.
Baltimore, Maryland 21215-0036	d within 72 ho giene. er then "natur itte Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired) Painter	rking	Kind of Business/Inc	,
land	d tal	To Be C	17. Father's Name (First, Middle, Last) Stephen Batts		ne (First, Middle, Maid nie Willian	•	
Mary	I and 2 shortealth and North and North and North Islama			Mailing Address <i>(Street and Number or Ru</i> 1006 Beachcraft Cour			
more,	of H		1 Burial 2 Cremation 3 Semoval from State	Disposition (Name of crematory or other place) of Cethsemane Feb.	18, R	Location - City or To	
Balt	pernit. Pag Department Importent: any injury o		21. Signature of Puneral Service Licensee	22. Name and Address of Facility Charles L. Stevens 1501 Fast Fort Ave P	altimore MD 2		
	cate be executed / Medical / Medical examiner   The price of the price	Examiner	Due to (or as a consequence of	1 Infarction Elerotic Meart Disea			Approximate Interval Between Onset and Death hours
Box 6	death certifi e attending od for use as	Physician/Medical	d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	3 □ Ectopic pregnancy 5 □ Other (specify)		23d. Date of delive Month	ry Day Year
rds, P.	ires tha signed d be de	by	Part II. Other significant conditions contributing to death but not resulting in the Hyperlipidemia	he underlying cause given in Part I.		o use contribute to the	e cause of death? ably 4 Unknown
Hec	The law ate has b page 2 sl	Completed			24a. Was an autopsy performed 1 Yes 2	prior to cor death?	osy findings available inpletion of cause of
	ding Physician: Th h. After this certificate funeral director, pag	on: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outp  27. Manne of Death 1 Natural 5 Pending  (Month, Day Year)  28b. Tir	atient 3 DOA Other: 4 Nursing H	ome 5 Residence 28d. Describe how in		<i>'</i> )
5	or Atten fler deat Sirector: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No n, street, factory, office	28f. Location (Street City or Town, Sta	and Number or Rura ate)	l Route Number,
	To the Hospitel within 24 hours a To the Funerel Completely filled	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place or investigation, in my opinion, death occu	, and due to the cause rred at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
1	To the within 2 To the Comple	Me	29b. Signature and titlefor certifier  Makeur Washendon	29c. License number D32800		Pate signed (Month, 1)	
	2		30. Name and address of p who completed cause of death (Item 23a) (T Hilary H, Washington MD 11701 Liv		Mashington,	MD20744	
	Sta Registr		31. Date filed (Month, Day, Year)  FEB 1 6 2006  32. Figure 3. Signature	Special			

CPM06-00092 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend UNpend item#2,232,27,29d,pen/E,6832,2716/06 IT State of Maryland / Department of Health and Mental Hygiene James Clark 1 - For Stata Registra Certificate of Death Rag. No. Decedent's Name (First, Middle, Last) 2. Date of Death 2006 3. Time of Death <sup>™</sup>05, Physician James A. Clark Jänuarv 1:11 ам /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Fort Washington Medical Center Fort Washington Prince George's | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug 25 2005 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10XM 2□ F 216-73-8169 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Director Annapolis 1 □XYes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1012 President St. S3 21403 Iteme 23a USA Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced 'natural' Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 0 N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) and Mental I James A. Clark Sr. Felicia Lyons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 I Felicia Lyons(Mother) 1012 President St. S3 Annapolis, Md. 21403 20b. Place of Disposition (Name of Bestelepacterest) Mean of 1 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any Injury or ot ance. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 1-12-06 Annapolis, Md. 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. 921 West St. Annapolis, Md. 21401 Larry B. Blese Mc0483 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Broncho neumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a donsecuaños of Examine The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medicai as attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death signed by the a 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by certificate hes been s rector, page 2 should 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of da......?
1 Yes 2 □ No autopsy performed? 2 ☐ No ours after death. eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient 2 ▼ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital within 24 hours a
To the Funeral I
completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (effect o To the 29b. Signature and hite of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. January 05.

State Registrar 31. Date filed (Month, Day, Year)
FEB 1 6 2006



e and address of person who completed cause of death (Item 23a) (Type, Print)

		Please 1 "The Please 1 23a, 27, 1 - For Registrar	State of Marylar	υераπтеп <i>Certificat</i>	e of Death	Reg. N		04493
		Decedent's Name (First, Middle, Last,				2. Date of Death	ay Year	3. Time of Death
Physici /Medio		KALEB F	R. Chea			February ·	4, 2006	4:20 A M
Examir	er	4a. Facility Name (If not institution, give	street and number)		Town, or Location of Death  Baltimore City		ic. County of Deat n/a	
uneral		Sinai Hospital  5. Social Security Number  6. Se	7. Age (In yrs.	last birthday) If Under		8. Date of Birth (Month, Day, Yea	9. Birti	hplace (State or Foreign untry)
irector		220-73-1513 10 Usual Residence of Decedent		Yrs.	14	12-21-	05 MIF	reghand
how	Ļ	10a. State 10b. County	10c. Ci	ty, Town or Location				10d. Inside City Limits 1 Yes 2 □ No
r 28a-f ehow	recto	Mod 10e. Street and Number		Jalti Ma		10g. 0	Citizen of What Co	
23a or	Funeral Director	3639 GLEr	idale Avo		21215		USF	7
iteme raserra	nue	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ No	.S. 13. Was Deced	dent of Hispanic Origin? (Spe cify Cuban, Mexican, Puerto I	city Yes or No- Rican, etc.)	14. Race - Ame Black, White	
rai, or	þ	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 🗆 Yes	2 No Specify:		Specify: BL	ack
netra	etec	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a. Decedent's Usua (Give kind of wo life. DO NOT us	rk done during most of workir	ng 16b.	Kind of Business/	Industry
The Mari	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	NA		NA	1	
d othe event,	Be	17. Father's Name (First, Middle, Last)	eatham		18. Mother's Name	(First, Middle, Maide	en Sumame)	
matic	၉	19a. Informant's Name/Relationship (Ty		19b. Mailing Address	(Street and Number or Rura	I Route Number, City	or Town, State, Z	Zip Code)
item 27 is marked other then other traumatic event, the Market traumatic event, the Ma		Venia Andre		1965	N. Colling	iton Av	_	to. Mel.
		20a. Method of Disposition  1 Burial Z Cremation 3 F	lemoval from State	Place of Disposition (Nar cemetery, crematory or o	ther place)	ate 20c.	Location - City or	Town, State
Importent: if eny injury or		4 Donaton 5 Other (Specify) 21. Signature of Funetal Service Licens	Ba	()	ematory 0//	IN. BRDAS	Purau Pri	Wa Hid.
E P		1 Gefran	alla		's metropoliti	un Chapa	L P.C	1
		shock, or heart failure List only or	ications that caused the deat ne cause on each line.	h. Do not enter the mod	le of dying, such as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death
sician ledical		Immediate & ause (Final / disease or condition resulting in death)	aSUDI ( Sudden  Due to (or as a conseq		eath in infancy)			
aminer		Sequentially list conditions	Due to (or as a consequence).	uence ory.				
ansit	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):				
rial-tra	Exar	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):				
physicien and the burial-tra	lical	(	d					
ettending pl	/Mec	IF FEMALE:	3c. If yes, outcome of pregna	ancy			23d. Date of deli	iverv
for t	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown				Month	Day Year
9	Phy	9 ☐ Unknown  Part II. Other significant conditions con		ulting in the underlying o	ause given in Part I	23e, Did tobacco	use contribute to	the cause of death?
ached	d by					1 ☐ Yes		
gned by the be detached	=					24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
2 should be detached	ple					performed?	death?	2□ No
ate has been signed by the page 2 should be detached	Completed	25. Was case referred to medical examiner?	lospital: t ☐ Inpatient 2√⊟	ÆR/Outpatient 3□ DC	26. Place of Death Other: 4 Nursing Hon	(Check only one) ne 5 ☐ Residence	6 ∏Other (Snow	cify)
cellinate has been signed by the rector, page 2 should be detached	Be	ANZAYes 2□No	424	28b. Time of 2		28d. Describe how in		5
this certificate has been signed by the al director, page 2 should be detached	To Be	27. Manner of Death	28a. Date of Injury (Month, Day Year)			ndetermined	and Number or P	Iral Route Number
rr. After this certificate has been signed by the ite funeral director, page 2 should be detached	To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	Fnd 2/4/2006	Fnd 3:40 AM		Rf Location /Street		and include the troops
r. After this certificate has been signed by the te funeral director, page 2 should be detached	To Be	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	(Month, Day Year) Fnd 2/4/2006  28e. Place of Injury - At hulding, etc. (Specif Found: reside	ome, farm, street, factory	, office 2	28f. Location (Street: City or Town, Sta pt 4F, Balti	imore, MD 2	ngyle Ave. 11215
rr. After this certificate has been signed by the it funeral director, page 2 should be detached	Certification: To Be	27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier (Check only) 27. Manner of Death 5 Pending investigation 6 Could not be determined	Fnd 2/4/2006  28e. Place of Injury - At he building, etc. (Specification)  Found: reside sician: To the best of my known on the basis of examina	ome, farm, street, factory y) nce	A at the time, date and place, a	pt 4F, Balti	(s) and manner as	21215 stated.
rr. After this certificate has been signed by the ie funeral director, page 2 should be detached	To Be	27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  29a. Certifier  1 Certifying Phy:	Fnd 2/4/2006  28e. Place of Injury - At hulding, etc. (Specific Found: reside	ome, farm, street, factory ETICE owledge, death occurred tition and/or investigation	A at the time, date and place, a	pt 4F, Balti and due to the cause ad at the time, date a	(s) and manner as	stated. to the cause(s)
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			For Stata Registrar			nd / Dep		of Heal	th and M	lental Hy	_	6	04494
ľ	Physici	an	Decedent's Name (First, Middle	Gladi	16		000	n		2. Date of De Month	Day	Year	3. Time of Death
1	/Medi			<u> </u>	1-	<del></del>				Feb		2006	05 - 7 MM
	Examir	ner	4a. Facility Name (If not institution 5502 Harris F	-	nber)			wn, or Loca rksvil	tion of Death		4c. County		
15%	Funanal		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday	If Under 1	/ear   If U	nder 24 Hrs.	8. Date of Bii (Month, Da			place (State or Foreign
	Funeral Director		577-30-3296	1□M 2X)F	95		Months D	ays Ho	urs Min.	April April	1 <i>y. Year)</i> 29 1910	Cour	yland
- 0	D.		Usual Residence of Decedent		10.00								
	arylar show	_	10a. State 10b. County			ty, Town or L						1	10d. Inside City Limits 1 ☐ Yes 2√2 No
	he M	ectc	MD Howa  10e. Street and Number	rd	C	larksv	10f. Zip Co	ndo.			10g. Citizen of	What Cour	
	with the or	급	5502 Harris F	arm Lane				1029			USA	Wilat Coul	itu y :
	leath ns 23	era	11. Marital Status	12. Was Dece	edent Ever in U	J.S. 13.			ic Origin? (Sp	ecify Yes or No Rican, etc.)		ce - Ameno	
936	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show myoritant: if item 27 is marked other than "natural", or items 23a or 28a-f show my Injury or other treumatic event, in Mydical Examinar must be notified at ance.	Completed by Funeral Director	1 Never Married 2 Mar	If Vac Cin	2 <b>∑</b> No ∕e		If Yes, specify  1 ☐ Yes 🎾			Rican, etc.)		ck, White, fy: Wh:	
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	sician: The law scertificate has E lirector, page 2 s	оше	Chranic	Renal	Fai	lure				auto perf	psy ormed? 2 X No	prior to co death? 1 \( \text{Yes} \)	mpletion of cause of
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of Vital	Physician: r this certifica ral director, r	To E	examiner? 1 □ Yes 2 X No	Hospital:	Inpatient 2	ER/Outpatie	ent 3 DOA	Other: 4	☐ Nursing Ho	ome 5 Res	idence 6 💢 Ot	her (Specif	m Living
0 0	ding Pt J. After th funeral		27. Manner of Death 1 XNatural 5 ☐ Pendii	28a. Date (Mon	of Injury th, Day Year)	28b. Time of Injury		. Injury at Work?		28d. Describe	how injury occu	rred	
Sio	Attending or death.  ector: After by the fune	catl	2 Accident investi	gation			М	1 Tes	2 No	00/ 1	(0)		
Division	or At	Certification:	4 Homicide determ	nined   288. Place	of Injury - At h ng, etc. <i>(Speci</i>	iome, farm, si ify)	treet, factory, o	ffice		City or To	Street and Num wn, State)	Der or Hura	al Route Number,
	pitel	S	29a. Certifier 1X Cartifyii	ng Physician: To the	hest of my kn	owledge dea	th occurred at	the time da	ate and place	and due to the	cause(s) and m	anner as s	tated
	To the Hospitel or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical		Examiner: On the b	asis of examination of stated.	ation and/or in	nvestigation, in	my opinion	, death occur	red at the time.	date and place	and due to	o the cause(s)
	To th To th sompl	Me	29b. Signature and title of certifie			40 0		icense nun	nber		29d. Date signe	ed (Month,	Dey, Year)
			•	XV	$\sim$ $^{i}$	no),	į	256	531		Feb	10,	9-00F
	10		30. Name and address of person Harry Li,		se of death (Ite	m 23a) (Type Ridge	Print) 2 Rd	,_ C	olumb	oik,	Feb MD3	2104	+4
	Sta		31. Date filed (Month, Day, Year,		gistrar's Sign	ature	111 .						
4	Regist	ar	FEB 1	6 2006	Misses .								

Physic /Medi	cal	Decedent's Name (First, Middle, Last)  Typone  4a. Facility Name (If not institution, give str	reet and number) Campbell 4b. City, Town, or Loc.	2. Date of Death  Month Day Year  7:09  ation of Death
Examir	ier	Mercy Hedical  5. Social Security Number 6. Sex	Counter Balting 7, Age (In vrs. last birthday) If Under 1 Year   If U	work and the state of Birth and the state of
Director		Usual Residence of Decedent  10a. State  10b. County	M 2□F 5 O Yrs. Months Days Ho	September 10, 1955 MD
r 28a-f show notified at	ector	MD N/A	Balt Mone	1 Dyes 2
or items 23s o	by Funeral Director	8 Z 9 A b b o H C  11. Marital Status  1 Never Married 2 Married	2. Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mi Yes 2 No If Yes, Give 1 Yes 2 No So	
an a	Completed b	3 Widowed 4 Divorced  15. Decedent's Educa (Specify only highest grade of Elementary/Secondary (0-12)	completed)  College (1-4or 5+)  (Give kind of work done during life. DO NOT use retired)	
nd Mental Hygiene. marked other than matic event, the M	To Be Co	17. Father's Name (First, Middle, Last)  Shirden Cay	npbell Laborer	Mother's Name (First, Middle, Maiden Sumame)  Jewe Shire JEAN SHIRD
f Health and item 27 is m other traum		Faith Camp bell 20a. Method of Disposition	9, Print) 19b. Mailing Address (Street and N	Aumber or Rural Route Number, City or Town, State, Zip Code)  Out Bulfmire MD 2/202  Date 20c. Location - City or Town, State
Department o important: If any injury or once.		1 Deurial 2 Cremation 3 Rer 4 Donation 5 Other (Specify)  21. Signature of Funeral Service Libensee	Mt-Zim Cem	2/18/06 Laws Jours MD
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hysician		23a. Part 1. Enter the disease, or complica shock, or heart lailure. List only one Immediate Cause (Final disease or condition resulting in death)	cause on each line.  Therstal Cuna	Facility Close Fineral Service, P. A. elain Relaid Buttimore MD 21206 St ch as cardiac or respiratory arrest.  Disease Disease
nysician Medical xaminer pe prijal-transit	Ical Examiner	shock, or heart lailure. List only one Immediate Cause (Final disease or condition	Thterstal Cung  Due to (or as a consequence of):	ch as cardiac or respiratory arrest, Approximate Interval Between Onset and Deat
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			For State Registrar		State of	Marylar		artmen rtificate			and M		Reg. No.	006	04496
	Physici	20	1. Decedent's Name (First, M.	ddle, Last)								2. Date of Dea	Day	Year	3. Time of Death
	/Medic		Kenneth S. C						-	L marking	( D th	FEBRUA			
	Examir	ier	4a. Fecility Name (If not institution HOSPITAI	_	treet and num	iber)			LKTON	Location o	or Death	4c. County of De			(r)
	Europal		5. Social Security Number	6. Sex	. 7	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under		8. Date of Birt	h	9. Birt	hplece (State or Foreign
Funeral Director 203–52–4825 12 M 2□F 44							Yrs.	Months	Days	Hours	Min.	(Month, Da 3-10-6			GA
	pu >000		Usual Residence of Decedent 10a. State 10b. Cou			10c Ci	ty, Town or Lo	ncation							10d. Inside City Limits
	taryla et at	5	MD Ceci			ĺ	ilkton	,041011							1 ☐ Yes XXNo
	28a-1	ect	10e. Street and Number					10f. Zip	Code					en of What Co	ountry?
	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other then "naturel", or items 23s or 28s-f show or other treumatic event, the Medical Examinar must be multified at	Funeral Director	136 Silcheste	r Dr					2192	21			Ţ	ISA	
	death	ner	11. Marital Status		12. Was Dece	dent Ever in U	.S. 13.	Was Deced	dent of His	spanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	- 1	4. Race - Ame Black, Whit	
98	or the	by Fu	1 Never Married 2		1 ☐ Yes If Yes, Give	2∯No e	ĺ	1 🗆 Yes	_	Specify:			1	Specify: Whi	te
21215-0036	hours ture!	q pe	3 Widowed 4 Divor	dent's Edu	Year or Da	ites:	16a. Dece	dent's Usua	al Occupa	ation			16b. Kin	d of Business	Industry
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Maryland	Ment Merke	၉	Lawrence Carm		C = 2.4		100 1400		(0)			a Farle	·	Tour State	Zin Codo)
Mar	12 sh h and 7 ts m	ηij	19a. Informant's Name/Relati		<sub>рө, Рппt)</sub> Wife							ton, MD			zip Coda)
dî.	of Health item 27 i	1	20a. Method of Disposition	y	WILL	20b. I	Place of Dispo					ate		ation - City or	Town, State
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Baltimore,	permit. Pages 1 Department of H important: If ite eny injury or ot once.	1	21. Simple of Funeral Sen			0	2	Name an	d Addres	s of Facilit	ty Lama	D 4		_	
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of \	hysio this co	၉	1 TYes 2 □ No	- 1			ER/Outpatie			4 - 140		me 5 Resi			ocify)
NO.	ling F	in o	27. Manner of Death 1 Natural 5 Pe			h, Day Year)	28b. Time of Injury	D M	28c. Injury Work	γαι k? Yes 2.1ΩΩ	1	Subject	ان في ا	& sho	by police
Division	Attending r death.	ficat	3 ☐ Suicide 6 ☐ Co	estigation uld not be ermined	2-11- 28e. Place	of Injury - At h	ome, farm, st	1				28f. Location (	Street and	Number or R	ural Route Number,
Σ	after after Dire	Certification:	4 Homicide de		buildir	ng, etc. (Speci	home		•			FLKtor	wn, State)		chester Drive
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral		29a. Certifier 1 ☐ Cert	fying Phys	sician: To the	best of my kn	owledge, deat	h occurred	at the tim	ne, date ar	nd place,	and due to the	cause(s)	and manner a	s stated. e to the cause(s)
	in 24 in 24 in Fi	edicai	one) 11		and mann	er stated.	ation and/or ir								
	with To T	Σ	29b. Signature and title of ce		4.			1		e number		1		signed (Mon	
	h		· W						0.C.	м.Е.		t	EBKU.	ARY 13	, 4000
	3		30. Name and address of per		mpleted cause	e of death (Ite	т 23а) (Туре,		חאיםם	אן כישט	יואינונד	D A T ጣቸልል	י יומי	MADEE 43	JD 01001
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			for State Registrar	State of I	Marylar		artmen rtificat				lental Hy	ygien Reg. N	211115	0	4497
П	Physic	ian	1. Decedent's Name (First, Middle	e, Last)							2. Date of D Month		ay Ye		3. Time of Death
	/Medi		Detrah A. Carter								FEBRU		15, 20		4:40 A
	Exami	ner	4a. Fecility Name (If not institution Saint Jose			en de en an	4b. City,	Town, or	Location of	_		4	c. County of D		
							14 1 1 - 4 -	4.14		OWS			Ba	alti	more
	Funeral Director		5. Social Security Number 213-04-6999	6. Sex 7.	Age ( <i>in yr</i> s. 24	last birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of B (Month, D 11-23-1	irth	7)	Country	e (State or Foreign
			Usual Residence of Decedent		24						11-23-1	901	Har	waii ́	
	yland		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d.	Inside City Limits
	Mar	ţō	MD NA				Balt	imore							1XXYes 2 ☐ No
	hours after death with the Maryland tural', or Items 23a or 28a-f show at Examiner must be notilised at	Director	10e. Street and Number				10f. Zip	Code				10g. C	itizen of What	Country?	?
	23a (23a)	alD	2035 Ruxton Avenue	2				21	216				USA		
	dea .	Funeral	11. Marital Status	12. Was Decede Armed Force		J.S. 13.	Was Deced			gin? (Sp	ecify Yes or N Rican, etc.)	0-	14. Race - A		
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Maryland 21215-0036	a the	ပို	17. Father's Name (First, Middle,	Last)		1000			18. Mothe	r's Name	e (First, Middle		Restaura	ant	
an		To Be	Felbret E. Carter										,		
J.	should and Men marke umatic	-	19a. Informant's Name/Relations			19b. Mailir	na Address	(Street a	nd Numbe		erie Mc		or Town, State	e Zin Coo	de)
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Ę	Pages nent of int: If it		1  Burial 2  □ Cremation 4  □ Donation 5  □ Other (S)		.0	ng Memori				2-20-0	06	Rand	allstown	, MD	
alti	보문문음.		21. Signature of Funeral Service	icensee	1 CCC		. Name an		s of Facility	у				,	
m	Depa Impo eny is		Sumerla	Jones		Wy	lie Fu	neral	Home	638 N	J. Gilmon	r St.	Balto,	MD 21	217
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S, F	ires tha signed d be del	>	Part II. Other significant conditio	ns contributing to death	but not resi	ulting in the un	nderlying ca	use give	n in Part I.		23e. Did	tobacco	use contribute	to the ca	ause of death?
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$\leq$	hysi his c	၉	1 ☐ Yes 2 No			ER/Outpatient	3 □ DO	Other	r: 4 🗌 Nur	sing Hor	ne 5 🗆 Resi	dence	6 □Other (S)	pecify)	
Ĕ	ing P	Ö	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of In (Month, D	jury Jay Year)	28b. Time of Injury	28	c. Injury Work	at ?	2	28d. Describe	how inju	ry occurred		
Division of	f or Attending Physician: after death. Director: After this cartification in by the funeral director.	Certification:		ot be 28e. Place of I	njury - At ho etc. <i>(Specif</i> )	ome, farm, stre	M et, factory,		es 2 N		28f. Location ( City or To	Street ar	nd Number or e)	Rural Ro	ute Number,
_	To the Hospital or Attending Physician: The within 24 hours after death, within 24 hours after death, To the Funeral Director: After this cartificate he completely filled in by the funeral director, page	Medical Ce	one)	Physician: To the bes examiner: On the basis and manner:	or examinal	wledge, death tion and/or inv	occurred a estigation,	t the time in my opi	e, date and nion, death	place, a	and due to the ed at the time,	cause(s date an	) and manner d place, and d	as stated ue to the	i. cause(s)
	To	2	29b. Signature and title of certifier	) ( .(	$\supset$	CM	29c.	License	number			29d. Da	te signed (Mo	nth, Day,	Year)
			Schard	L. Lait	Ficu	u	Sound	31	826			2-	15-6	06	
	7		30. Name and address of person v	no completed cause of	death (Item	23a) (Type, F	Print)								
	Sta		RICHARD L. I. 31. Date filed (Month, Day, Year)	32. Regis	trar's Signa	76.011 ture	DSLE	R D	RIVE	TO	WSON	MAR	YLAND-		10/4

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Unpend item#23a,23c,27,28a-f,pen/E,6852,2/21/06 IT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Denise Crowe** 1457 Feb 3, 2006 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 M 20 F Months Yrs 219-06-0308 21 Oct 8, 1984 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland N/A Baltimore 1¥ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4140 Duane Avenue - 2nd Floor 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Black Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MVA Customer Agent II 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Dennis M. Crowe Stephanie A. White 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephanie A. White Mother 4140 Duane Avenue - 2nd Floor Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 02/13/06 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Livens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Meperidine Intoxication Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3□Ectopic pregnancy 5XXOther (specify) Elective termination in the past 12 months? 1 Ayes 2 □ No Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed?

/Medical Examiner i by the attending physicien and stached for use as the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 been signed by the should be detached certificate To the Hospital or Attending Physician: completely filled in by the funeral director, this After death. after death within 24 hours a To the Funeral C

**Physician** 

/Medical

**Examiner** 

Director

Funerai

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Completed

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2

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Physician/Medical

2

Completed

Be P

Certification:

Medical

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heatth and Mental Hyglene.
ant: If item 27 is marked other then "natural; or items 23a or 28a-1 show ury or other traumatic event, Ir.a Medical Examinational be notified at

portant: I

permit.
Departrimports
any inju

Physician

Baltimore, Maryland 21215-0036

				1 Yes 2 No 1 Yes 2 No					
25. Was case referred to medical	26. Place of Death (Check only one)								
examiner? 1 XYes 2 □ No	Hospital: 1 Inpatient 2 ER/Outp	patient 3	DOA Other: 4 Nursing H	dome 5 Residence 6 □ Other (Specify)					
27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of Injury 28b. Ti	me of jury	28c. Injury at Work?	28d. Describe how injury occurred	-				
2 X Accident investigation 3 ☐ Suicide 6 ☐ Could not be	2/3/2006 1:47	РМ	1 ☐ Yes 2 📉 No	Accidental intoxication					
4 Homicide determined	28e. Place of Injury - At home, farr building, etc. (Specify)	m, street, fact	28f. Location (Street and Number or Rural Route Number City or Town, State 877 Baltimore & Appropriate Research						
	Medical clinic			Annapolis Blvd. Severna Park, M	)				

29a. Certifier (Check only one)	1☐ Certifying Phy 2☑ Medical Exam	 To the best of my knowledge, death occur in the basis of examination and/or investigated and manner stated.	red at the time, date and place, and due to th tion, in my opinion, death occurred at the time	e cause(s) and manner as stated.  a, date and place, and due to the cause(s)
29b. Signature and	d title of certifier		29c. License number	29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2006

OCMB February 4, 2006 Penn St. BALTO MD 21201

31. Date filed (Month, Day, Year) State 16 EB Registrar

32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** OR ETTA DRNISH 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore Baltimore** Rock Glen Nursing Home If Under 1 Year If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□ M 2 F Director Mar 15, 1922 220-12-7237 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show treumatic event, the Medical Experience relative nufficient 1 □ Xes 2 □ No Director Baltimore Maryland N/A 10g. Citizen of What Country? 10e Street end Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or any injury or other treumatic event, the Medical Examinet Francisco. 4711 Dartford Avenue 21229 U.S.A. Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married ☐ Yes 2☐ No Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced **Black** 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Baltimore County Public** Housekeeping Service 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Cooper John Bolden 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 4711 Dartford Avenue Baltimore, Maryland 21229 Lucinda Duffin Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Mills, Md. 02/22/06 Garrison Forest Veterans Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 sease, or complications that daused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, ure. List only one cause on each line. Approximate Intervel Between Onset end Death Part1. Enter the **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical DEBILITY Examiner Due to (or as a consequence of): Physiclan/Medical Examiner use as the buriel-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, to (or as a consequence of) 23b. Did tobacco use contribute to the ceuse of deeth? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been signed by þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was en autopsy performed? Be Completed has 1 ☐ Yes 2 ♣No 2 No 1 🗆 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: Wursing Home 5 Residence 6 Other (Specify) Certification: To 1 🗆 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No efter death Director: / 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 - Homicide Hospital of 24 hours e 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 1 6 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 04500 1 - For State Ragistrar Certificate of Death Rag. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2:12 рм **Physician** do /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Baltimore Halethorpe 1939 Lincoln Ave. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Sept 22, 1927 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Maryland 1<del>√</del>M 2□ F 78 217-24-3946 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ?? Is marked other than "natural", or Iteme 23a or 28a-1 show traumatic event, the Mardical Examinar must be notified at 1 ☐ Yes 2€ No Halethorpe MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21227 U.S.A. 1939 Lincoln Ave. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status within 72 hours after tyckyes 2 No 1946 If Yes, Give 171946 Year or Dates: 7/1947 1 Never Married 2 Married Specify: White 1 ☐ Yes 20XNo Specify: Maryland 21215-0036 δ 35 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 hand Mental Hygiene.
7 Is marked other than "! Elementary/Secondary (0-12) College (1-4or 5+) Freight United Airlines 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Jensen John Doyle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Importent: If Item 27 Is m eny Injury or other traum 2006. 5020 Brampton Parkway Ellicott City MD 21043 Janet Guchhait/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 2-11-2006 Pikesville, MD Parkwood Cemetery 4 □ Donation 5 □ Other (Specify) Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus MD 21227 21. Signature of Funeral Service Luceus de 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Advanced Dementiz **Physician** /Medical Due to (or as a consequence of) Examiner Cardio pulmonary Arrest enclostive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury to (or as a consequence of). Examiner or Attending Physicien: The law requires that the death certificate be executed signed by the attending physicien and it is detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 🗌 Probably 4 Onknown Completed should 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 2 No 1 Yes 1□ Yes this certificate 26. Place of Death (Check only director, 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 No 3 DOA Certification: To 28d. Describe how injury occurred After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death To the Funerel Director: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai (Check only one) and manner stated ů, 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 02-09-2006 36786 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie UD 21000 Read Kolsler 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar 6